

11436

CERTIFICATE OF DEATH

Reg. Dist. No. 11432

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>WASH.</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 4749</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KALL'S NURSING HOME</u>  |                                  | d. STREET ADDRESS <u>705 18th ST. N.W.</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Lula</u> Last <u>Adams</u>   |                                  | 4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1958</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 29 1877</u>                             |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |                                  | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>John C. House</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Clellie Baird</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                  | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT <u>Mrs. Eugenia J. Seeger</u>  |                                  | Address <u>1150 Conn. Ave. NW Wash. 6, D.C.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart</u><br>(c) <u>Diabetes</u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of race <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>   |                                  | 20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>   |   |
| 21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>58</u> , to <u>10/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <u>Lawrence A. Rapee</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. NW Wash. 6, D.C.</u> DATE SIGNED <u>10/1/58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>LAWRENCE A. RAPEE, M.D.</u>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>   | 22b. DATE THEREOF <u>10/3/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE Cem.</u>   | 22d. LOCATION (City, town, or county) (State) <u>FINDLAY OHIO</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Bauder</u> ADDRESS <u>1756 Penna. Ave. NW</u>   |                                  | 24a. REC'D BY REGISTRAR <u>ACT 3 '58</u>   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                 |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11/23/20

*Signature of Doctor*  
*Signature of Informant*  
*Signature*

*10/1/20*  
*8/2/20*  
*5/26/20*  
*2/2/20*

*BARBARA A. THURTELL MD.*

*105 Can for Mr. Thurtell*

*11/23/20*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11437 CERTIFICATE OF DEATH

Reg. Dist. No. 11433

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY                                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>   |  |
| c. LENGTH OF STAY IN 1b <u>4 yrs.</u>   |   | d. STREET ADDRESS <u>1105 "G" ST. S.E.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rolls Nursing Home, 7429 Maple Ave., Takoma Park</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mollie</u> Middle <u>none</u> Last <u>Allen</u>   |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>8</u> Year <u>1958</u>  |  |
| 5. SEX <u>F.</u>  | 6. COLOR OR RACE <u>W.</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 30-1876</u>  |
| 9. AGE (In years last birthday) <u>82</u> yrs.  |   | IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Henry Larkin</u>   |   | 14. MOTHER'S MAIDEN NAME <u>MARY MARIE SCHULTZ</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>1105 "G" ST. S.E. Wash. D.C.</u>  |  |
| 17. INFORMANT <u>James A. Allen</u>   |   | Address <u>1105 "G" ST. S.E. Wash. D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u><br>450.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. 19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>7/3</u> , 1956, to <u>10/1</u> , 1958, that I last saw the deceased alive on <u>October 1</u> , 1958, and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <u>James M. Whitlock</u>   |   | ADDRESS (Street, city or town, state) <u>7701 Carroll Ave. Takoma Park, Md.</u>  |  |
| PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>  |   | DATE SIGNED <u>10/8/58</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>10-10-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>  | 22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>  |   | ADDRESS <u>Washington D.C.</u>   |  |
| 24a. REC'D BY REGISTRAR <u>OCT 10 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneel</u>   |  |





## 11438 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Pennsylvania</u> b. COUNTY <u>Delaware</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>  |  |
| c. LENGTH OF STAY IN 1b <u>1 day 8 1/2 hrs.</u>   |                               | d. STREET ADDRESS <u>5603 Berks St.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Samuel</u> Middle <u>(NMN)</u> Last <u>Allen</u>  |                               | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>15</u> Year <u>1958</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/15/87</u>                    |
| 9. AGE (In years last birthday) <u>71</u> yrs.  |                               | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer man</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Jacob Allen</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Zeida (Unknown)</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>unknown</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>  </u>   |  |
| 17. INFORMANT <u>Washington Sanitarium + Hosp. Record</u>   |                               | Address <u>  </u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion.</u><br>DUE TO (c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>33 HRS.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>   |                               |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)  |                               | 20g. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>10-14-58</u> , 19 <u>  </u> , to <u>10-15-58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>10-14-58</u> , 19 <u>  </u> , and that death occurred at <u>6:12</u> M., from the causes and on the date stated above.  |                               |   |  |
| ACTUAL SIGNATURE <u>Richard R. Clapp</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park, Md</u>  |  |
| DATE SIGNED <u>  </u>   |                               | DATE <u>  </u>  |  |
| PHYSICIAN'S NAME (Type) <u>  </u>   |                               | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |
| 22b. DATE THEREOF <u>10/17/58</u>   |                               | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Jacobs Cem.</u>   |  |
| 22d. LOCATION (City, town, or county) (State) <u>Collingsdale, Penna.</u>   |                               | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Langensky</u> ADDRESS <u>3501-14 St NW. D.C.</u>   |  |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11435

11469

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY                     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b> <b>47X-3</b>                                    |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | d. STREET ADDRESS<br><b>4708 Southern Avenue, SE</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>William</b> Last <b>Andree</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>12</b> Year <b>1958</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 3, 1900</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>58</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Projectionist</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Movie Industry</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Henry Andree</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Etta McCord</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>WW I Unascertainable</b>  |  |  |  |
| 17. INFORMANT<br><b>The Medical Record</b>   |  |   |  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>430.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Staphylococcal Endocarditis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Uremia</b> |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>September 23 1958</b> to <b>October 12, 1958</b> , that I last saw the deceased alive on <b>October 12, 1958</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>James C. Kirby Jr.</i> M.D.   |  |   |  | DATE SIGNED<br><b>10-13-58</b>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>James C. Kirby, M.D.</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center<br/>National Institutes of Health<br/>Bethesda 14, Maryland</b>                             |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |  | 22b. DATE THEREOF<br><b>10/15/58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cem</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Calmar Manor, Md</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>G. Wm Lee's Sons Co</i>   |  |   |  | ADDRESS<br><b>300 4th St N.E.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>1 4 '58</b>                                |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Frank</i>  |  |  |  |

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07-2004/11-1114-10 (20) 11/01/2004 11:17:00 AM

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11439

Reg. Dist. No.

|  |                                  |   |  |   |  |   |   |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Latona Park</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>9 hrs</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>56 Silver Springs</u>                                  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium &amp; Hosp.</u>   |                                  |   |  | d. STREET ADDRESS<br><u>10012 Brackmoor Dr.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Dora</u> Middle <u>Alice</u> Last <u>ARBOGAST</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>7</u> Year <u>19 58</u>  |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8-21-65</u>  |  | 9. AGE (In years last birthday)<br><u>93</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>LUTHER BOND</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown. WOLFDER</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>Hospital Records</u> Address  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, MASSIVE</u><br>900.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>SKULL FRACTURE, LEFT FRONTO-PARIETO-SPHENOID</u><br>DUE TO<br>(c) <u>11</u>   |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>9 HOURS</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell down stairs at home</u>                             |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>10-6</u> P. M. <u>1958</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   |  | 20f. (City or town) (County) (State)<br><u>Silver Spring Montg Md</u>                             |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Notural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <u>Frank J. Bluscar</u>   |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| EXAMINER'S NAME (Type) <u>FRANK J. BLUSCAR</u>   |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
|  |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)   |   |
| <u>Trans. &amp; burial</u>   |                                  | <u>10/10/58</u>   |  | <u>SUNSET MEM. CEMETERY</u>   |  | <u>CLARKSBURG, WEST VIRGINIA</u>  |   |
| 23. FUNERAL DIRECTOR'S NAME (Type) <u>Raymond H. Ziska</u>   |                                  |   |  | ADDRESS<br><u>Silver Spring, Md.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>DATE OCT 9 '58</u>  |   |
|  |                                  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11470 CERTIFICATE OF DEATH

11437

Reg. Dist. No.

|   |  |   |  |   |  |  |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> |  | c. LENGTH OF STAY IN b<br><b>10 Days</b>  |  | 2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)<br>d. STATE<br><b>West Virginia</b>   |  | e. COUNTY<br><b>Fayette</b>  |  | f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Summerlee</b> |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  | d. STREET ADDRESS<br><b>P.O. Box 113</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 3. NAME OF DECEASED (Type or print)<br>First<br><b>Larry</b>   |  | Middle<br><b>Wayne</b>   |  | Last<br><b>Baber</b>   |  | 4. DATE OF DEATH<br>Month<br><b>October</b>  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 29th, 1950</b>  |  | 9. AGE (In years last birthday)<br><b>8</b> yrs                    |  | IF UNDER 1 YEAR<br>Months<br><b>8</b>  |  | IF UNDER 24 HRS<br>Days<br><b>15th,</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Earl K. Baber</b>                          |  | 14. MOTHER'S MAIDEN NAME<br><b>Dorothy Burgess</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                             |  |
| 16. SOCIAL SECURITY NO<br><b>None</b>   |  | 17. INFORMANT<br><b>The Medical Record</b>  |  | Address<br><b>The Clinical Center, Bethesda, Maryland</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1040</b><br>DUE TO<br>(b) <b>pulmonary insufficiency (respiratory insufficiency)</b><br>DUE TO<br>(c) <b>Immediate postoperative correction of tetralogy of Fallot &amp; atrial septal defect</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Congenital heart lesion</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1040</b>                    |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o m p. m.<br><b>19</b>                              |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>Bethesda</b>                             |  | (County)<br><b>Montgomery</b>  |  | (State)<br><b>Md.</b>  |  |
| 21. I certify that I attended the deceased from <b>October 5, 1958</b> , to <b>October 15, 1958</b> , that I last saw the deceased alive on <b>October 15th, 1958</b> , and that death occurred at <b>7:35 A.M.</b> from the causes and on the date stated above. |  |   |  |   |  |  |  |  |  |  |  | DATE SIGNED<br><b>10/15/58</b>   |  |
| ACTUAL SIGNATURE<br><b>N. Perryman Collins, M.D.</b>  |  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b>                                 |  | The National Institutes of Health<br><b>Bethesda 14, Maryland</b>   |  | PHYSICIAN'S NAME (Type)<br><b>N. Perryman Collins, M.D.</b>  |  | 22a. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill, W. Virginia</b> |  | 22b. LOCATION (City, town, or county)<br><b>Wash., D.C.</b>  |  | 22c. DATE<br><b>OCT 16 '58</b>   |  |
| 22d. DATE OF REMOVAL (Specify)<br><b>Removal</b>  |  | 22e. DATE THEREOF<br><b>10/15/58</b>  |  | 22f. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill, W. Virginia</b>  |  | 22g. LOCATION (City, town, or county)<br><b>Wash., D.C.</b>  |  | 22h. DATE<br><b>OCT 16 '58</b>                                     |  | 22i. NAME OF CEMETERY OR CREMATORY<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>                   |  | 22j. LOCATION (City, town, or county)<br><b>Wash., D.C.</b>  |  |
| 22k. NAME OF CEMETERY OR CREMATORY<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>  |  | 22l. LOCATION (City, town, or county)<br><b>Wash., D.C.</b>   |  | 22m. DATE<br><b>OCT 16 '58</b>  |  | 22n. NAME OF CEMETERY OR CREMATORY<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>   |  | 22o. LOCATION (City, town, or county)<br><b>Wash., D.C.</b>        |  | 22p. DATE<br><b>OCT 16 '58</b>   |  | 22q. NAME OF CEMETERY OR CREMATORY<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

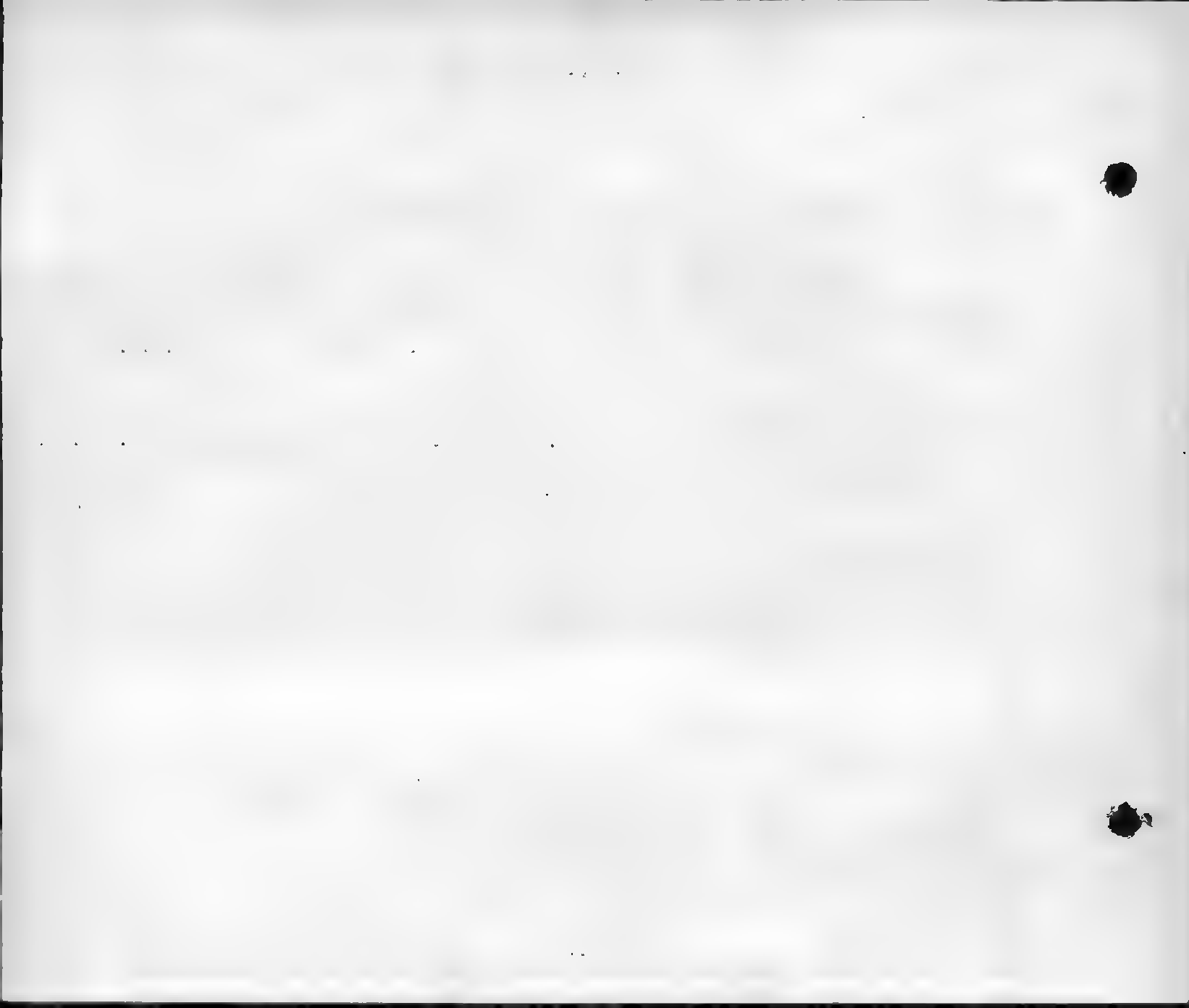
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471

## CERTIFICATE OF DEATH

Reg. Dist. No. 11438

|  |                                  |   |                                 |
|--|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Chevy Chase</b>   |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Le Deau Nursing Home</b>  |                                  | d. STREET ADDRESS<br><b>5525 Graystone Street</b>   |                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HUGO</b> Middle <b>BACHARACH</b> Last <b>BACHARACH</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>29</b> Year <b>1958</b>   |                                 |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1872</b> |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.  |                                  | 10. IF UNDER 1 YEAR: Months <b>30</b> Days <b>15</b> Hours <b>00</b> Min <b>00</b>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Meat Dealer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Frankfort, Germany</b>  |                                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                 |
| 13. FATHER'S NAME<br><b>Samuel Bacharach</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Johanna Marx</b>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>Mr. Joseph P. Dratch -5525 Graystone St., Ch.Ch., Md.</b>                              |                                 |
| 17. INFORMANT<br><b>Mr. Joseph P. Dratch -5525 Graystone St., Ch.Ch., Md.</b>  |                                  | Address   |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Insufficiency</b><br>470.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cerebrovascular</b><br>DUE TO<br>(c) <b>Coronary Insufficiency - Cerebrovascular</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 days - 15 years.</b>  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary Insufficiency - Cerebrovascular on Oct 11, 1958.</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                 |
| 21. I certify that I attended the deceased from <b>1953</b> to <b>Oct 29, 1958</b> , that I last saw the deceased alive on <b>Oct. 28, 1958</b> , and that death occurred at <b>230 P.M.</b> from the causes and on the date stated above.   |                                  |   |                                 |
| ACTUAL SIGNATURE <b>Samuel Dessoiff</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>1302-188th H. Wash DC</b>  |                                 |
| PHYSICIAN'S NAME (Type) <b>SAMUEL DESSOFF</b>  |                                  | DATE SIGNED <b>10/29/58</b>   |                                 |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-31-58</b>  |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>King David Memorial Garden</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Falls Church Virginia</b>   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bernard Danzansky &amp; Sons-3501 14th St., NW</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>Nov 2 '58</b>   |                                 |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur P. K...</b>  |                                  |   |                                 |





11472

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Tennessee</u> b. COUNTY                                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>16 days</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><u>The Clinical Center, Bethesda 14, Md.</u>   |  |   |  | d. STREET ADDRESS<br><u>259 W. Market Street</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Georgia</u> Middle <u>Lee</u> Last <u>Bacon</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>4</u> Year <u>1958</u>  |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 2, 1936</u>                                       |  |
| 9. AGE (In years last birthday)<br><u>22</u> yrs.   |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>            |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Dental Technician</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dentistry</u>                                     |  | 11. BIRTHPLACE (State or foreign country)<br><u>Tennessee</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                              |  |
| 13. FATHER'S NAME<br><u>Elmer R. Williams</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Nellie Hodge</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><u>Not available</u> |  | 17. INFORMANT<br><u>The Medical Record</u><br><u>The Clinical Center, Bethesda 14, Maryland</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Irreversible Hypotension</u><br><u>648.1</u> DUE TO<br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Intraabdominal Hemorrhage</u><br>DUE TO<br>(c) <u>Chorioadenoma Desecans</u> |  |   |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min.</u><br><u>3 days.</u><br><u>6 mos.</u>   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Idiopathic - possibly toxic</u>   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> e. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <u>September 18, 1958</u> , to <u>October 4, 1958</u> , that I last saw the deceased alive on <u>October 18, 1958</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.                                 |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Donald A. Kellogg</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>                          |  |  |  |
| DATE SIGNED <u>10-4-58</u>  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Donald A. Kellogg, M. D.</u>   |  |   |  |   |  |  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>10/7/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sulphur Springs</u>  |  | 22d. LOCATION (City, town or county) (State)<br><u>Washington Co., Tenn.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-Bethesda, Maryland</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 7 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11473

## CERTIFICATE OF DEATH

Reg. Dist. No 215

|  |                           |   |  |  |   |
|--|---------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery MARYLAND  |                           |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br>Virginia<br>b. COUNTY |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |                           | c. LENGTH OF STAY IN 1b<br>25 days  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Fairfax                    |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. Naval Hospital   |                           |   | d. STREET ADDRESS<br>Route #3, Box 539   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Walter Max BAUER   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>October 23 1958  |  |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>January 28, 1894   |  | 9. AGE (In years last birthday)<br>64 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Civil Service   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>U. S. Navy   |  | 11. BIRTHPLACE (State or foreign country)<br>Minnesota   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13. FATHER'S NAME<br>Frederick BAUER   |                           |   | 14. MOTHER'S MAIDEN NAME<br>Louise CLAUS   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes WWI   |                           | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT Address<br>(W) Mrs. Flora S. Bauer, same as #2 above   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma stomach with metastases</i><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                           |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>8 mos.  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that I attended the deceased from Sept. 28, 1958, to Oct. 23, 1958, that I last saw the deceased alive on Oct. 23, 1958, and that death occurred at 3:10 A. M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>U. S. Naval Hospital, NMMC 10-23-58   |                           |   |  |  |   |
| ACTUAL SIGNATURE <i>W. D. Hooper</i> M D U. S. Naval Hospital, NMMC 10-23-58   |                           |   |  |  |   |
| PHYSICIAN'S NAME (Type) W. D. HOOVER, LT MC, USN Bethesda 14, Maryland   |                           |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>10-27-58   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington National   |   |
|  |                           |   |  | 22d. LOCATION (City, town, or county) (State)<br>Arlington Virginia  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>C. M. Jones</i><br>Ives Funeral Home, 2847 Wilson Blvd, Arlington,  |                           |   | 24a. REC'D BY REGISTRAR<br>OCT 27 '58  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Kraus</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



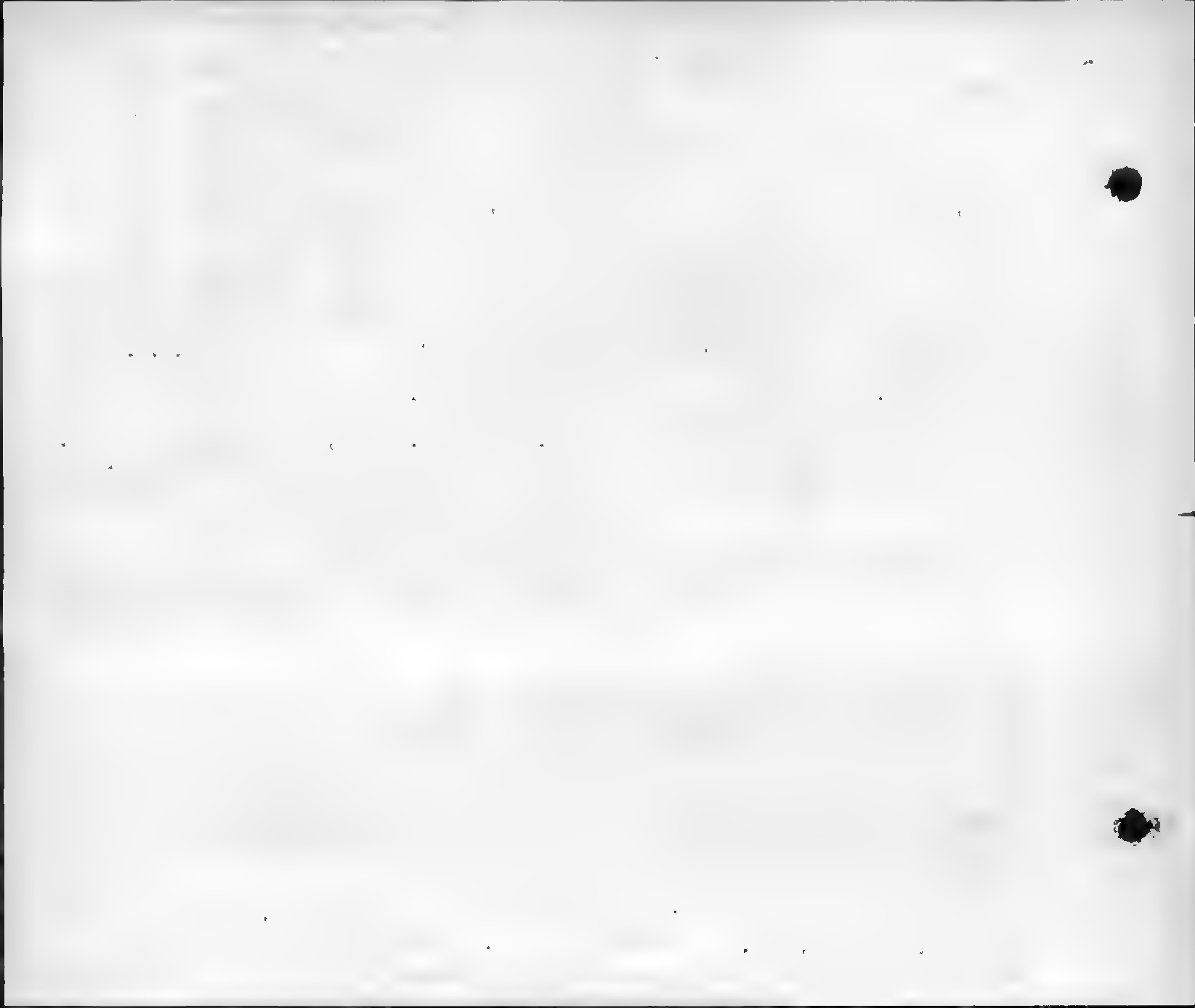
## 11474 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                    |   |  |  |  |
|--|----------------------------------|---|------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>3 years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>11,504 NEWPORT MILL ROAD</b>   |                                  |   |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>L</b> Last <b>BEALL</b>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>11</b> Year <b>19 58</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/24/01</b> | 9. AGE (In years last birthday)<br><b>57</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Engineer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pa. Railroad</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Frank E. Beall</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Mary F. McFarland</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>  |                                  | 16. SOCIAL SECURITY NO  |                                    | 17. INFORMANT<br>Address<br><b>Mrs. Mildred E. Beall, 11504 Newport Mill Rd. Silver Spring, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 12 hours</b> |                                  |   |                                    |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 1, 1958</b> to <b>October 11, 1958</b> that I last saw the deceased alive on <b>October 11, 1958</b> and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>12020 Morgan Rd. Silver Spring, Md.</b> DATE SIGNED <b>10/11/58</b><br>ACTUAL SIGNATURE <b>PC JAMESON</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>PC JAMESON</b>   |                                  |   |                                    |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>11/14/58</b>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN CEMETERY</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>PRINCE GEO. COUNTY, MARYLAND</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Ziska</b>   |                                  |   |                                    | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton A. Frank</b>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

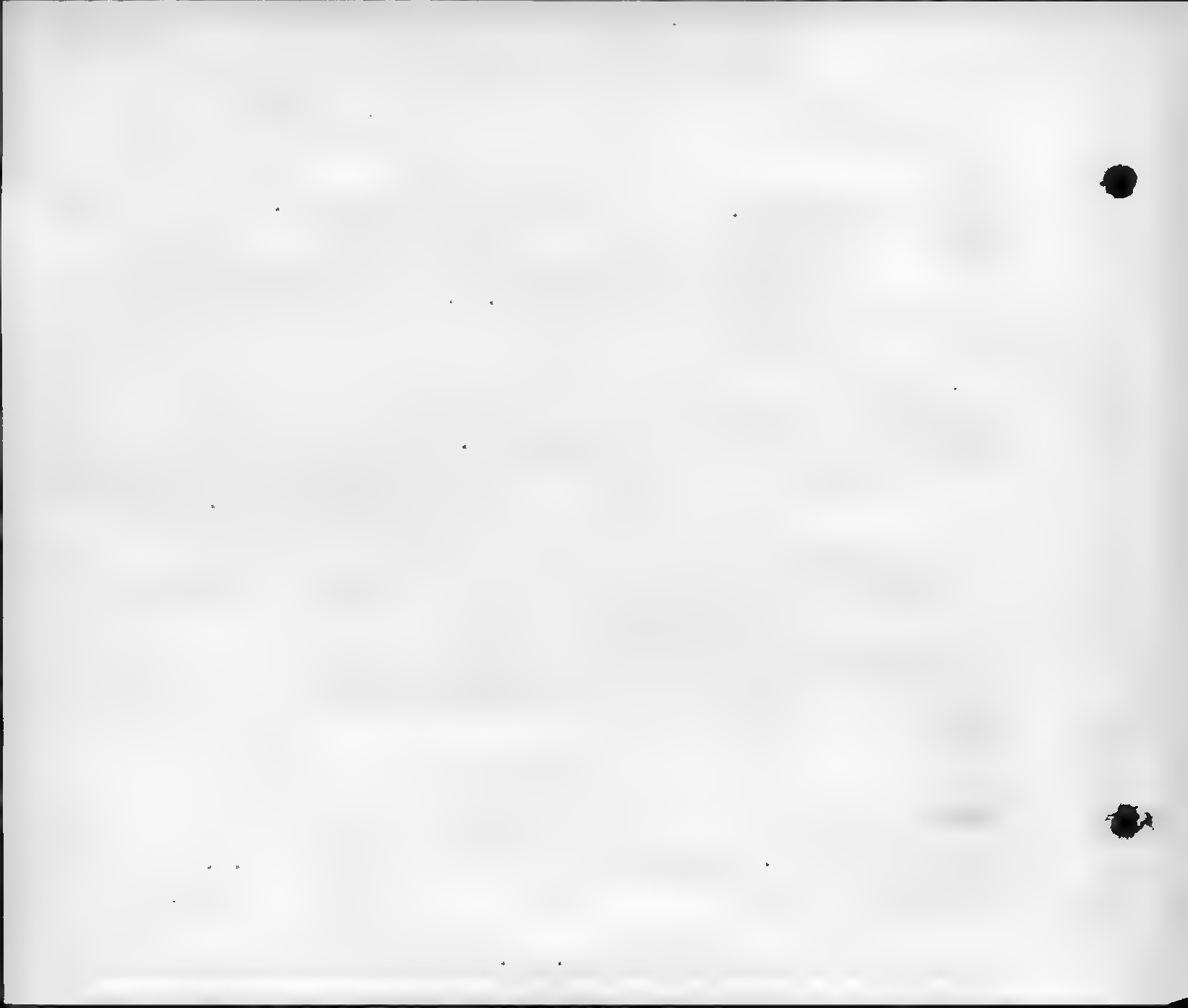
11475 CERTIFICATE OF DEATH

11442

Reg. Dist. No.

|   |                              |   |   |   |  |  |   |
|---|------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kenwood</b>  |                              |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Kenwood</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5305 Chamberlain St.</b>   |                              |   |   | d. STREET ADDRESS<br><b>5305 Chamberlain St.</b>  |  |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              |   |   |   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>Lewis</b> Last <b>Bell</b>   |                              |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>9</b> Year <b>19 58</b>   |  |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 3, 1888</b> | 9. AGE (In years last birthday)<br><b>70</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | IF UNDER 24 HRS<br>Hours <b>0</b> Min. <b>0</b>                        |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Executive</b>   |                              |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>New Mexico</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                              |   |   |   |  |  |   |
| 13. FATHER'S NAME<br><b>Neill Bell</b>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Susan Woolfolk</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)   |                              |   |   | 16. SOCIAL SECURITY NO.<br><b>225-10-1028</b>   |  | 17. INFORMANT<br><b>Rachel S. Bell</b>                                 |   |
|   |                              |   |   | Address<br><b>5305 Chamberlain St.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>5 years</b><br>(c) <b>5 years</b> |                              |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Venous Stasis</b>   |                              |   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                              |   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town)   |                              |   |   | 20g. (County)   |  | 20h. (State)   |   |
| 21. I certify that I attended the deceased from <b>3-3</b> , 19 <b>44</b> to <b>10-9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-8</b> , 19 <b>58</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.  |                              |   |   |   |  |  |   |
| ACTUAL SIGNATURE<br><b>Walter K. Myers</b> M.D.   |                              |   |   | DATE SIGNED<br><b>Washington 10-9-58</b>  |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>Walter K. Myers</b>   |                              |   |   | ADDRESS<br><b>3011 45th Street, N.W.</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur &amp; Rem</b>   |                              | 22b. DATE THEREOF<br><b>10/11/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Potosi Wisconsin</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Wisconsin</b>      |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Sander's Sons</b>   |                              |   |   | ADDRESS<br><b>1756 Penna. Av. NW</b>  |  | 24a. REC'D BY REGISTRAR<br><b>OCT 14 '58</b>                           |   |
|   |                              |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kous</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

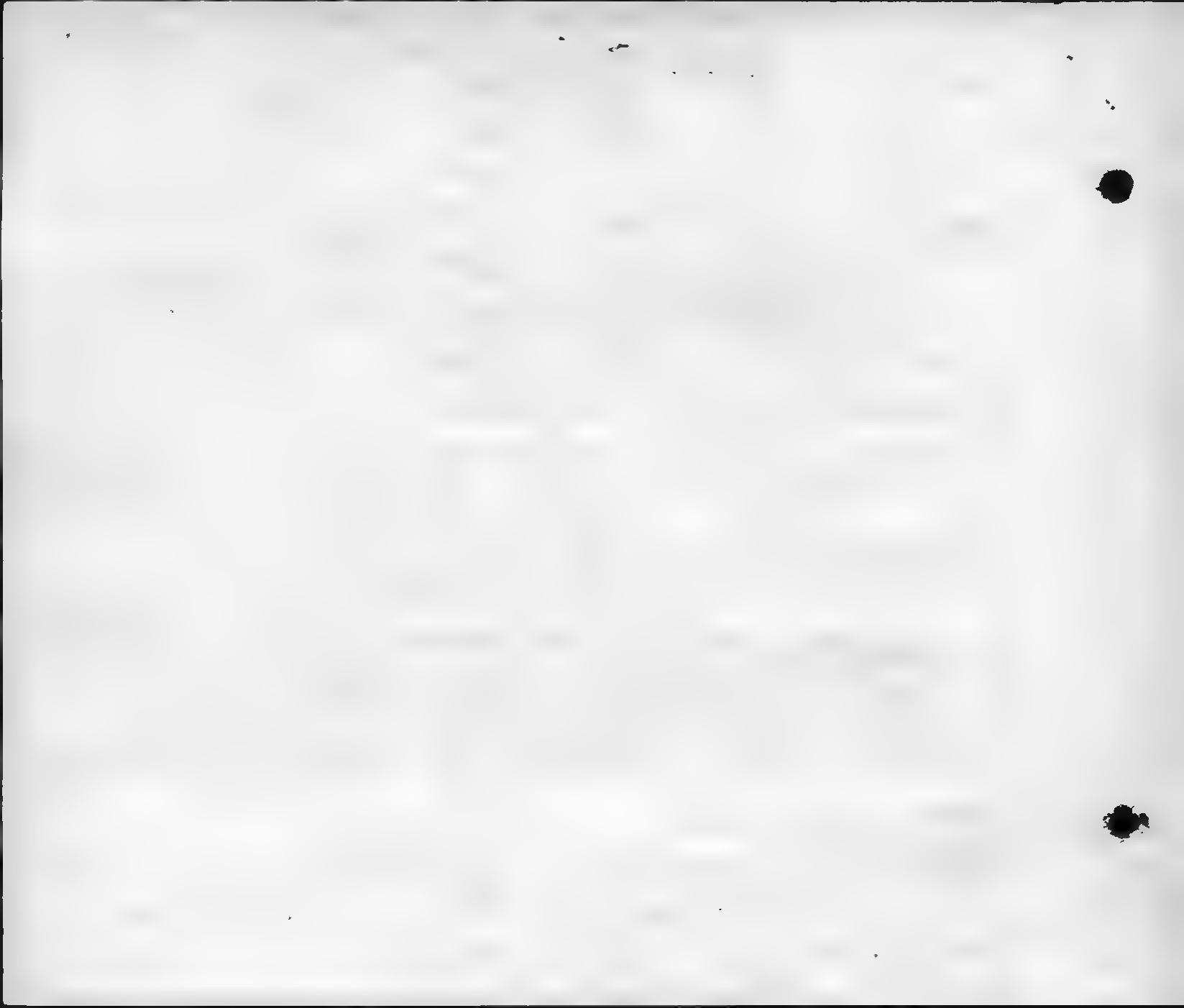


## 11476 CERTIFICATE OF DEATH

11443  
Reg. Dist. No.

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                           | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Pa.</i> b. COUNTY <i>Philadelphia</i>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Philadelphia</i>   |                                      |
| c. LENGTH OF STAY IN 1b <i>1 mo</i>   |                           | d. STREET ADDRESS <i>5327 Baynton St.</i>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home</i>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Bertha</i> Middle <i>Bennett</i> Last <i>Bennett</i>  |                           | 4. DATE OF DEATH<br>Month <i>Oct</i> Day <i>6</i> Year <i>1958</i>   |                                      |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec. 1, 1897</i> |
| 9. AGE (In years last birthday) <i>60</i> yrs.  |                           | IF UNDER 1 YEAR: Months <i>10</i> Days <i>5</i> Hours <i></i> Min. <i></i>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <i>M. J.</i>  |                           | 12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>  |                                      |
| 13. FATHER'S NAME <i>Alphonza Bennett</i>   |                           | 14. MOTHER'S MAIDEN NAME <i>Mary Smith</i>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>N.C.</i> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <i>None</i>  |                                      |
| 17. INFORMANT <i>Mrs. Mary B. Old</i>   |                           | Address <i>Washington, D.C.</i>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i><br><i>500X</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i></i> DUE TO (c) <i></i> |                           | INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>   |                           |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i></i>   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <i>19</i> p. m. <i></i>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>  |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <i>8/1</i> , 19 <i>58</i> , to <i>12/6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/1</i> , 19 <i>58</i> , and that death occurred at <i>1:30</i> P. M., from the causes and on the date stated above.  |                           |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                           | 22b. DATE THEREOF <i>10/10/58</i>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Cold Springs Cem</i>  |                           | 22d. LOCATION (City, town, or county) (State) <i>Cape May, New Jersey</i>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>  |                           | 24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>   |                                      |
| ADDRESS <i>Bethesda, Maryland</i>   |                           | DATE <i>OCT 8 '58</i>  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





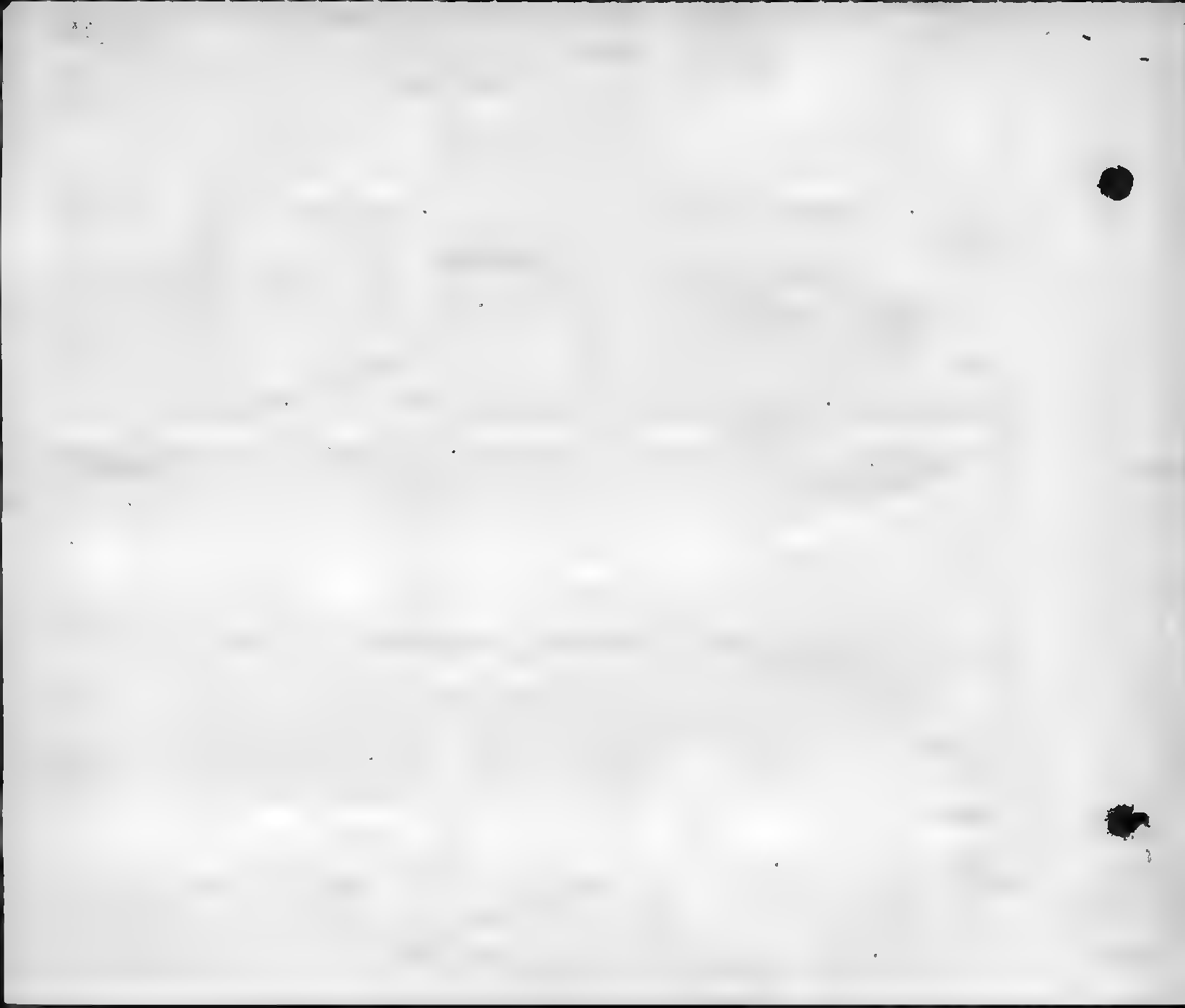
## 11464 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |   |  |  |  |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>26 Rockville</b>                                       |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>318 W. Montgomery Avenue</b>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>ADELE</b> Last <b>BENNETT</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>9</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 27, 1873</b> |   | 9. AGE (In years last birthday)<br><b>85</b> yrs | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>12</b>                              | IF UNDER 24 HRS<br>Hours <b></b> Min <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>UBA</b>                                     |  |
| 13. FATHER'S NAME<br><b>George H. Bennett</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ema Mays Bennett</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>None</b>   |   | 17. INFORMANT<br><b>Lillian A. Bennett-sister-same as 2d</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Thrombosis</b><br>(c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>4th Bone Marrow Transfusion 1st day</b> |                                  |   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a. m.</b> <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>11/25/55</b> to <b>10/12/58</b> , that I last saw the deceased alive on <b>10/9/58</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>Rockville, Maryland</b> DATE SIGNED <b>10/10/58</b>  |                                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.   |                                  |   |   | PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b> <b>Rockville, Maryland</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/12/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Union Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Burtonsville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  |   |   | ADDRESS<br><b>Bethesda, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DA 14 '58</b>                                    |  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. E. Thayer</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22d File # 17-24-56 et

## CERTIFICATE OF DEATH

11445

Reg. Dist. No.

11477

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>10110 CENTER RD.</u>  |                                  | d. STREET ADDRESS<br><u>10110 CENTER RD.</u>   |   |
| 3 NAME OF DECEASED<br>(Type or print) First <u>MARIE</u> Middle <u>ANNA</u> Last <u>Barthmeyer</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>20</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 27 1916</u> |
| 9. AGE (In years last birthday)<br><u>41</u> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><u>GAGE CO. NEBRASKA</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |   |
| 13. FATHER'S NAME<br><u>George D. Sykes</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>MARILDA THICKMAN</u>  |   |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                                  | 16 SOCIAL SECURITY NO.<br><u>NONE</u>  |   |
| 17. INFORMANT<br><u>VARNITA BARTHOLOMEW</u>  |                                  | Address<br><u>501 GARDEN RD. Silver Spring</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]  |                                  |  |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY INFARCT</u>   |                                  |  |   |
| DUE TO (b) <u>Metastatic Adeno Carcinoma</u>   |                                  |  |   |
| DUE TO (c) <u>Adeno Carcinoma - Primary in Breast</u>  |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>  |                                  |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Oct. 1</u> 19 <u>58</u> , to <u>Oct. 20</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10-20</u> 19 <u>58</u> , and that death occurred at <u>A.H.M.</u> , from the causes and on the date stated above. |                                  |  |   |
| ACTUAL SIGNATURE <u>Robert H. Craft</u> MD   |                                  | ADDRESS (Street, city or town, state) <u>1515 E. FIDELITY RD. Silver Spring, Md.</u>   |   |
| PHYSICIAN'S NAME (Type) <u>ROBERT H. CRAFT</u>   |                                  | DATE SIGNED <u>OCT 20 1958</u>   |   |
| 22a BURIAL CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF  |   |
| 22c. NAME OF CEMETERY OR CREMATORY   |                                  | 22d LOCATION (City, town, or county) (State)   |   |
| <u>TRANS. &amp; BURIAL OCT. 22, 1958</u>   |                                  | <u>EVERGREEN HOME CEMETERY BEATRICE, GAGE CO., NEBRASKA</u>  |   |
| 23 FUNERAL DIRECTOR'S SIGNATURE<br><u>WARNER E. PUMPHREY, INC.</u>   |                                  | ADDRESS<br><u>SILVER SPRING, MD.</u>   |   |
| 24a REC'D BY REGISTRAR<br><u>Raymond C. Zarka</u>  |                                  | 24b REGISTRAR'S SIGNATURE<br><u>W. J. K. K...</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11478 CERTIFICATE OF DEATH

11446

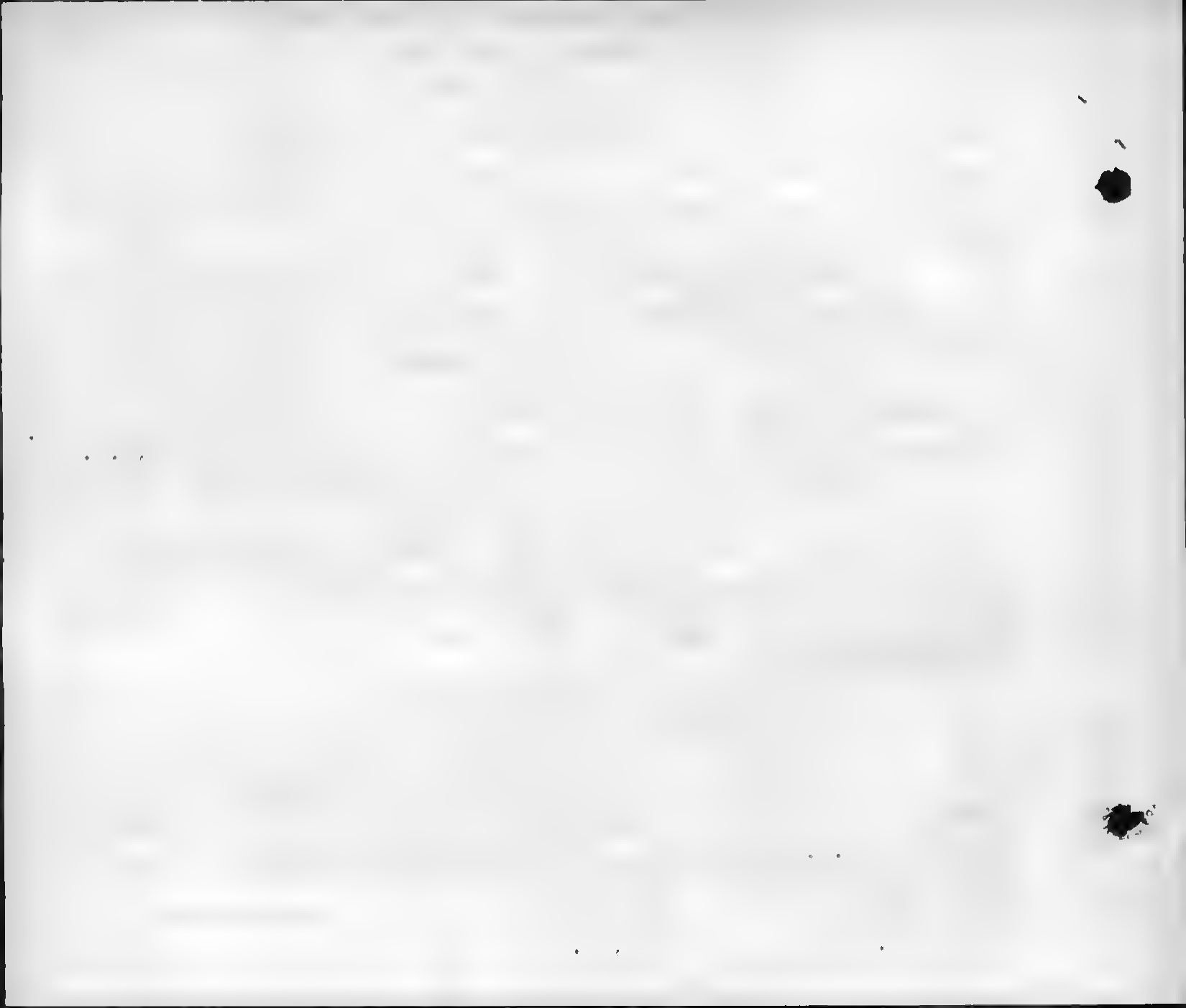
Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission)<br>b. COUNTY <u>9th Juris</u>                                      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colney</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eaton Town</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Brokee Grove Foundation</u>  |  |  |  | d. STREET ADDRESS <u>River Dale Farm</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Crispin Bernard</u>  |  |  |  | 4. DATE OF DEATH Month Day Year <u>Oct 27 1958</u>   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>Cauc</u>           |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Jan 24 1879</u>  |  |
| 9. AGE (In years last birthday) <u>79</u> yrs   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>N. G.</u>                               |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>David Crispin</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Martha Bennett</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>J. L. Bernard</u> Address <u>440 Riverdale Ave. Eatontown, N.J.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerosis Heart disease</u>  |  |  |  |  |  |  |  |
| DUE TO (b) <u>Myocarditis</u>   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)               |  |
| 20f. (City or town)   |  |  |  | 20g. (County)  |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <u>Jan 2 - 1957</u> to <u>10 - 27 - 1958</u> that I last saw the deceased alive on <u>7-30-1958</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>J.W. Bird</u>   |  |  |  | ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>  |  |  |  | DATE SIGNED <u>10/27/58</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  |  | 22b. DATE THEREOF <u>10/27/58</u>      |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 28 1958</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>J. L. Bernard</u>                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11440 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>New Jersey</u><br>b. COUNTY                               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>1 mth +</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elizabeth</u>  |  |  |  |
| f. STREET ADDRESS <u>82 Summit Rd.</u>   |  |   |  | • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Dorothy Hill Bibbs</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>4</u> Year <u>1958</u>   |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH <u>12-23-94</u>                                       |  |
| 9. AGE (In years last birthday) <u>63</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Minn.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>America</u>                            |  |
| 13. FATHER'S NAME <u>Clarence Reynolds</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Hill</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>—</u>   |  |  |  |
| 17. INFORMANT <u>Hospital Records</u>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Phlebotrombosis</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pulmonary embolism</u><br>DUE TO<br>(c) <u>Myocardial infarction</u> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 + 4 days</u><br><u>10 - 14 days</u>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>e. m.</u> <u>19</u> p. m.   |  |   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |  |   |  | 20g. (County)  |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <u>9/28/58</u> to <u>10/3/58</u> that I last saw the deceased alive on <u>9/28/58</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.  |  |   |  |  |  |  | DATE SIGNED <u>10/4/58</u>   |
| ACTUAL SIGNATURE <u>Chas. H. WoloHon</u>   |  |   |  | ADDRESS (Street, city or town, state) <u>M.D. WASHINGTON SANITARIUM, TAKOMA PARK, MD.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>CHAS. H. WOLOHON</u>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>Burial</u>   |  | 22b. DATE THEREOF <u>Oct. 8, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>   |  | 22d. LOCATION (City, town, or county) <u>Elizabeth, New Jersey</u>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>   |  |   |  | 24a. REC'D BY REGISTRAR <u>DATE OCT 5 58</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

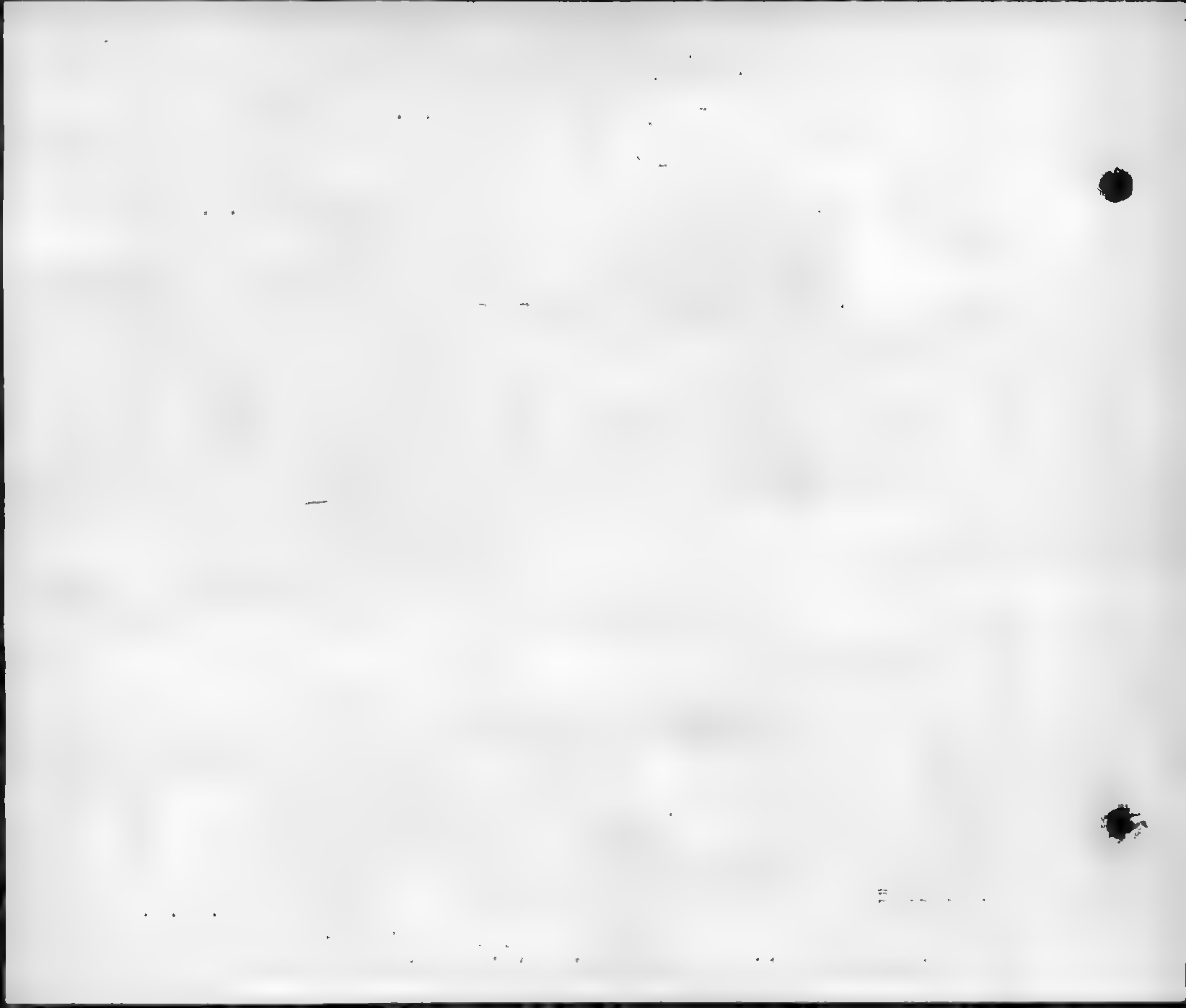




## 11479 CERTIFICATE OF DEATH

Reg. Dist. No. 11448

|   |  |                                  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY                                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>8-12-58</b>   |  |                                  |  | d. STREET ADDRESS<br><b>Apt 432<br/>1601 Argonne Place N.W.</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Hall Nursing Home</b>  |  |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Belle</b> Middle <b>Bassett</b> Last <b>Blackley</b>  |  |                                  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>4</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-28-1865</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>93</b> yrs.   |  | IF UNDER 1 YEAR: Months Days     |  | IF UNDER 24 HRS: Hours Min   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Texas</b>   |  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 13. FATHER'S NAME<br><b>Robert Bassett</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Scott</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |                                  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT<br><b>Nursing home records</b>  |  |                                  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c)]   |  |                                  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>DUE TO <b>Coronary sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)  |  |                                  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b><br><b>10 yrs +</b>   |  |                                  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |                                  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>July 19 1958</b> to <b>4 Oct 1958</b> , that I last saw the deceased alive on <b>4 Oct 1958</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>1150 Conn. Ave. 4 Oct 1958</b><br>DATE SIGNED<br>ACTUAL SIGNATURE <b>P. Massie Page</b> M.D.<br>NAME (Type) <b>P. MASSIE PAGE</b> |  |                                  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMAINS (Specify)   |  | 22b. DATE THEREOF                |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| <b>burial</b>   |  | <b>10/7/58</b>                   |  | <b>Rock Creek Cemetery</b>   |  | <b>Washington, D.C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>  |  |                                  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 8 58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Robert L. Hines</b>                   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11480 CERTIFICATE OF DEATH

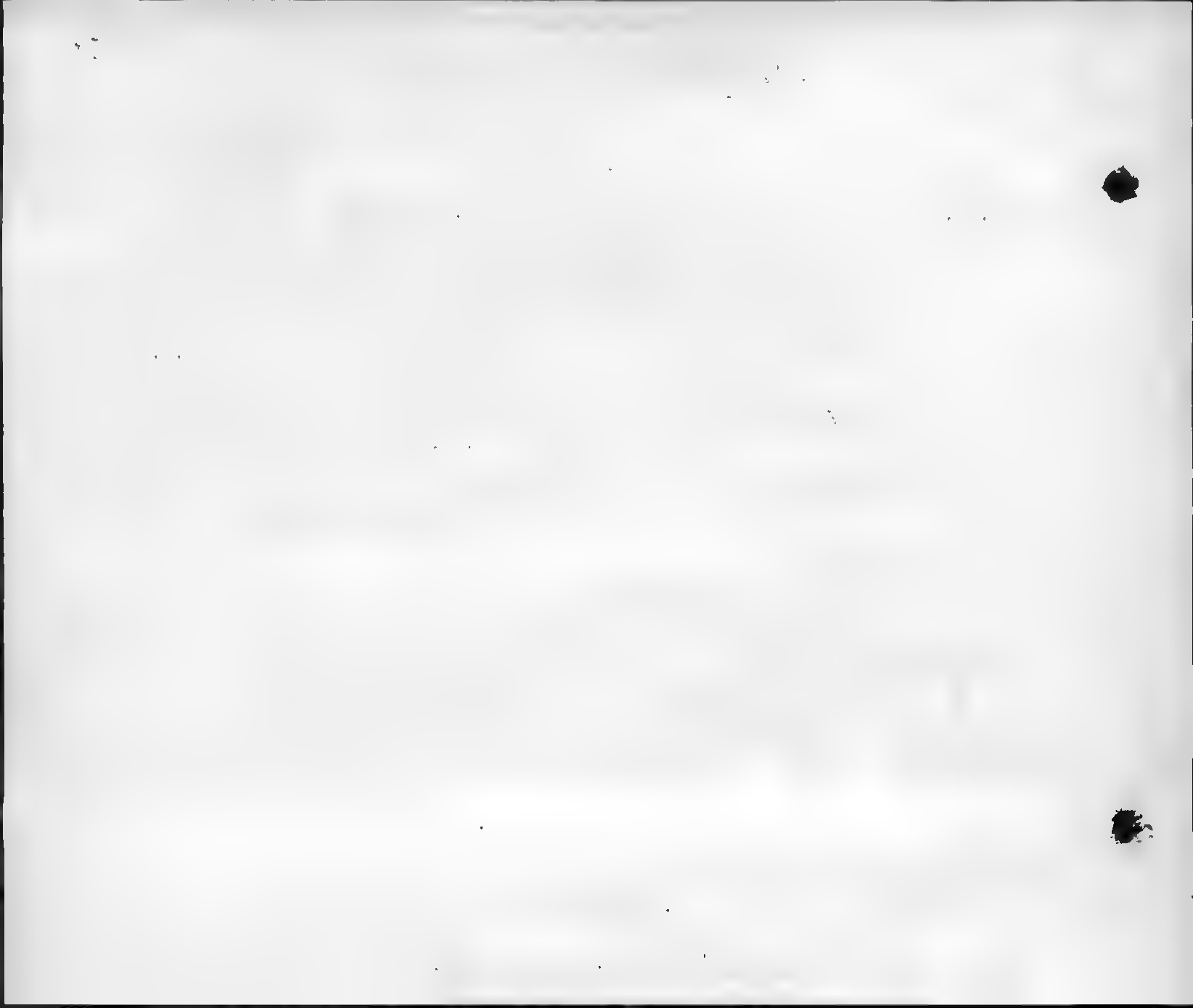
11449  
215

Reg. Dist. No.

|  |                           |   |                              |   |   |   |   |
|--|---------------------------|---|------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |                           |   |                              | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br>Virginia |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |                           |   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Arlington               |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. Naval Hospital   |                           |   |                              | d. STREET ADDRESS<br>904 S. Orme Street   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Richard Houston BLAIR   |                           |   |                              | 4. DATE OF DEATH<br>Month Day Year<br>October 24 1958   |   |   |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-24-58 |   | 9. AGE (In years last birthday) yrs<br>50 |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |                              | 11. BIRTHPLACE (State or foreign country)<br>Bethesda, Maryland   |   | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.                               |   |
| 13. FATHER'S NAME<br>Robert Charles BLAIR  |                           |   |                              | 14. MOTHER'S MAIDEN NAME<br>Della Catherine MOOG  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No  |                           | 16. SOCIAL SECURITY NO<br>None  |                              | 17. INFORMANT<br>(F) Robt. C. Blair, same as #2 above   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fetal Anoxia<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |                           |   |                              |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |   |                              |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                              |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                              | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |   | 20f. (City or town) (County) (State)                                |   |
| 21. I certify that I attended the deceased from October 24, 1958, to October 24, 1958, that I last saw the deceased alive on October 24, 1958, and that death occurred at 1:50 A.M. from the causes and on the date stated above                                       |                           |   |                              |   |   |   |   |
| ACTUAL SIGNATURE<br>Kenneth W. Sell  |                           | ADDRESS (Street, city or town, state)<br>U. S. Naval Hospital, NNMC   |                              |   |   | DATE SIGNED<br>10-24-58   |   |
| PHYSICIAN'S NAME (Type)<br>Kenneth W. SELL, LT, MC, USN  |                           | Bethesda 14, Maryland   |                              |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>10-27-58   |                              | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |   | 22d. LOCATION (City, town, or county) (State)<br>Arlington Virginia |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Ives Funeral Home, 2847 Wilson Blvd., Arlington, VA  |                           |   |                              | 24a. REC'D BY REGISTRAR<br>OCT 27 '58   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kiana                       |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11481 CERTIFICATE OF DEATH

11450

Reg. Dist. No.

|  |                           |   |                                     |   |                 |  |                 |
|--|---------------------------|---|-------------------------------------|---|-----------------|--|-----------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           |   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY |                 |  |                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Paul</u>   |                           |   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>                 |                 |  |                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>  |                           |   |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |                 |  |                 |
| 3. NAME OF DECEASED (Type or print) <u>BARNETT BLUM</u>  |                           |   |                                     | 4. DATE OF DEATH <u>Oct. 31 1958</u>  |                 |  |                 |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 1-1874</u> | 9. AGE (In years last birthday) <u>84</u> yrs.  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT Retired</u>  |                           |   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY <u>POLAND</u>   |                 | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                 |
| 13. FATHER'S NAME <u>Isabel</u>  |                           |   |                                     | 14. MOTHER'S MAIDEN NAME <u>Isabel</u>  |                 |  |                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |                           |   |                                     | 16. SOCIAL SECURITY NO. <u>577-52-7206A</u>   |                 | 17. INFORMANT <u>Morris Blum, Silver Spring</u>  |                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CEREBRO-VASC. THROMBOSIS</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL &amp; GEN. ATHEROSCLEROSIS</u><br>DUE TO (c) _____ |                           |   |                                     |   |                 | INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u>   |                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |                                     |   |                 | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                          |                 |  |                 |
| 20c. TIME OF INJURY Hour <u>a. n.</u> Month, Day, Year <u>19</u>   |                           |   |                                     | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>                |                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |                 |
|  |                           |   |                                     | 20f. (City or town) _____ (County) _____ (State) _____  |                 |  |                 |
| 21. I certify that I attended the deceased from <u>JUN</u> , 1957, to <u>Oct. 31</u> , 1958 that I last saw the deceased alive on <u>Oct. 29</u> , 1958, and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above  |                           |   |                                     |   |                 |  |                 |
| ACTUAL SIGNATURE <u>Jack J. Rheingold</u> M.D.   |                           |   |                                     | ADDRESS (Street, city or town, state) <u>1302 18th St. NW</u>   |                 |  |                 |
| PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>   |                           |   |                                     | DATE SIGNED <u>10/31/58</u>   |                 |  |                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>Nov 2-1958</u>   |                                     | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon Cem</u>  |                 | 22d. LOCATION (City, town or county) (State) <u>Hallsville MD</u>                              |                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. ...</u> ADDRESS <u>4217-9th St NW</u>  |                           |   |                                     | 24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>  |                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

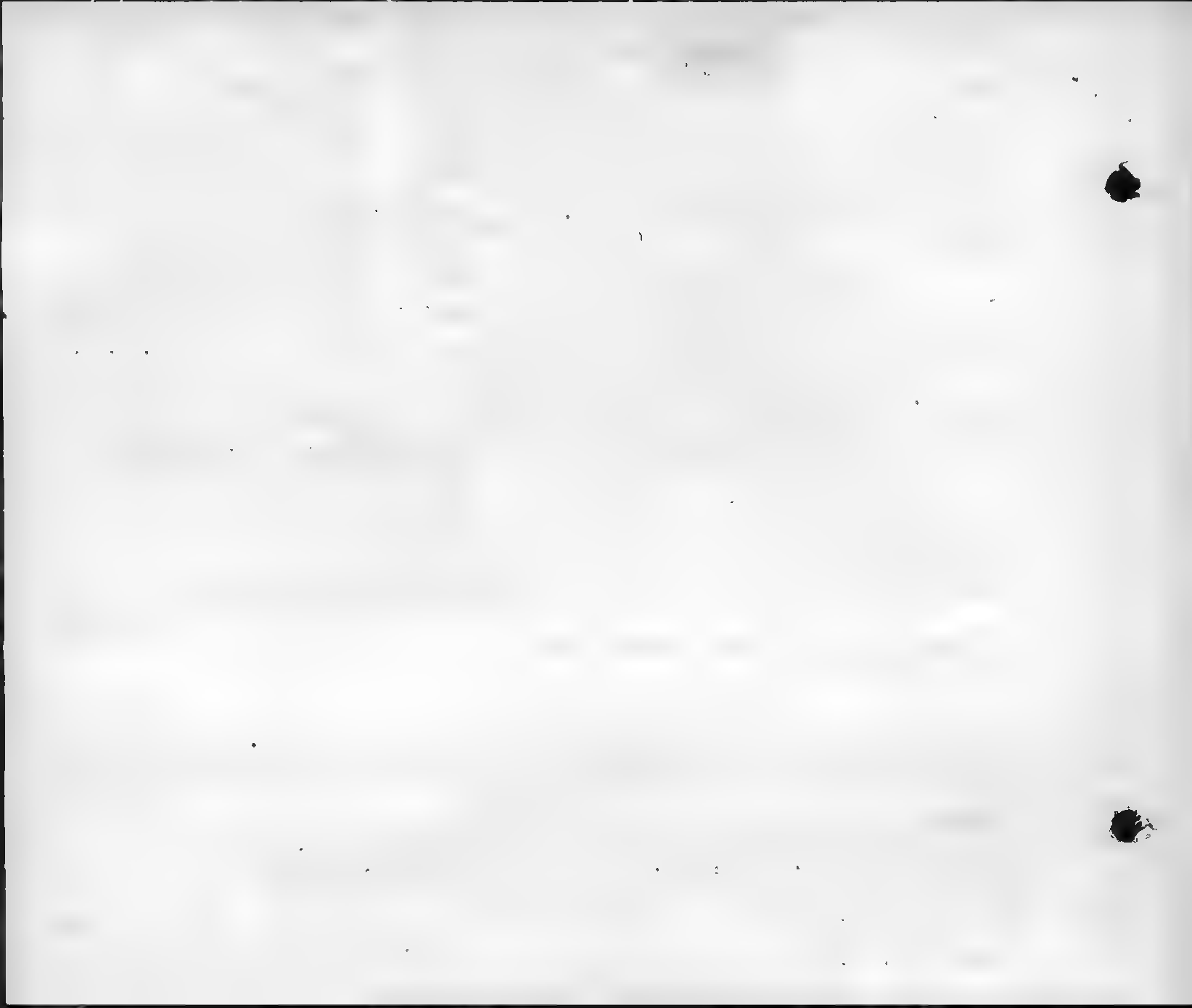
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11482 CERTIFICATE OF DEATH

11451

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |  |   |  | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <b>Virginia</b> b. COUNTY <b>Prince Edward</b>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>35 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <b>Leni</b> Middle <b>(H)</b> Last <b>Boggs</b>   |  |   |  | 4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>19 58</b>   |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>October 20, 1906</b>  |  |
| 9. AGE (In years last birthday) <b>51</b> yrs   |  | IF UNDER 1 YEAR Months <b>51</b>  |  | IF UNDER 24 HRS Days <b>51</b> Hours <b>51</b> Min <b>51</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School Teacher</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>               |  |
| 13. FATHER'S NAME<br><b>John H. Rohrabach</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Sipe</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>Unascertainable</b>   |  |   |  |
| 17. INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CAUSE OF DEATH</b><br>DUE TO (b) <b>PAROTITIS SUPPURATIVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c) <b></b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1</b>                                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>September 2, 1958</b> , to <b>October 7, 1958</b> , that I last saw the deceased alive on <b>October 7, 1958</b> , and that death occurred at <b>12:53 A.M.</b> from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>James M. Marsh, M.D.</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10/7/58</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>James M. Marsh, M.D.</b>   |  |   |  | National Institutes of Health<br><b>Bethesda 14, Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-Transit</b>   |  | 22b. DATE THEREOF<br><b>10/8/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Alderson Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Alderson, West Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  |   |  | ADDRESS<br><b>Bethesda, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>OCT 8 '58</b>                                     |  |
|   |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>(Signature)</b>                                |  |



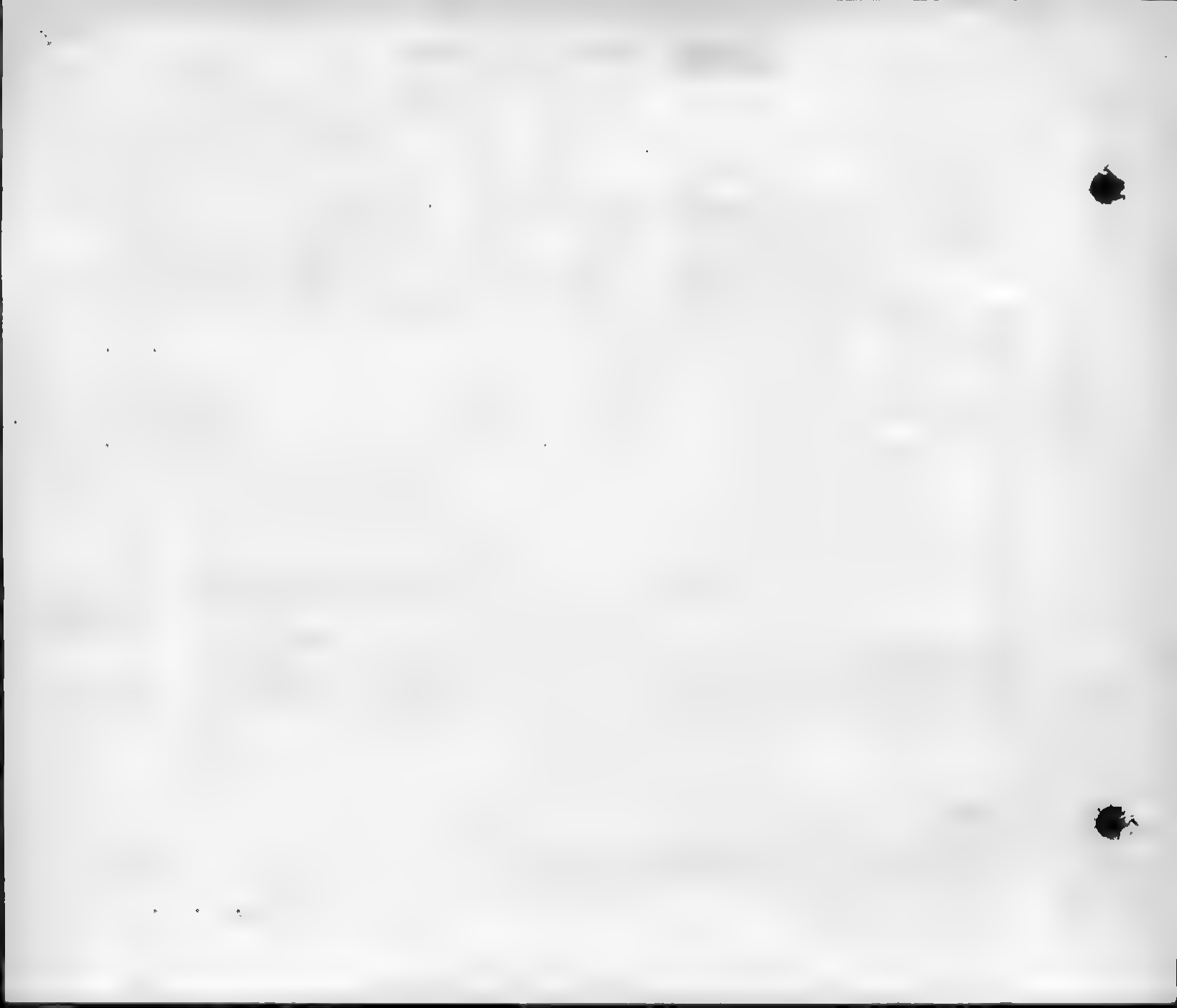


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11483 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 hour</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>   |  |   |  |
| f. STREET ADDRESS<br><b>4307 Elm. Street</b>   |  |   |  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>EFFIE Florence BOWEN</b>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><b>October 7 1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 17, 1879</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>79 yrs</b>   |  | 10. IF UNDER 1 YEAR Months Days Hours Min |  | 11. IF UNDER 24 HRS Months Days Hours Min  |  | 12. IF UNDER 1 YEAR Months Days Hours Min                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Stafford Co., Virginia</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Mace Perkins</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marion Wallace Monteith</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO   |  |   |  |
| 17. INFORMANT <b>Son</b> Address <b>5419 Roosevelt St. Bethesda, Md.</b>   |  |   |  | 18. C. Lee Bowen   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  |   |  |
| PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b>  |  |   |  |  |  |   |  |
| 42001 DUE TO <b>ACUTE MYOCARDIAL INFARCTION.</b> 2 HRS.  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> 20 YRS   |  |   |  |  |  |   |  |
| (c)  |  |   |  |  |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>6/23</b> 19 <b>53</b> , to <b>10/7</b> 19 <b>58</b> , that I last saw the deceased alive on <b>10/7</b> 19 <b>58</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>9300 Ewing Drive Bethesda, Md.</b> DATE SIGNED <b>10/7/58</b> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Seymour Greenbaum</b> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <b>SEYMOUR GREENBAUM, M.D.</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/10/58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. H. Niles Co. 2901-14th St. N. W.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>Oct 10 58</b>  |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |  |   |  | 24c. REGISTRAR'S SIGNATURE   |  |   |  |

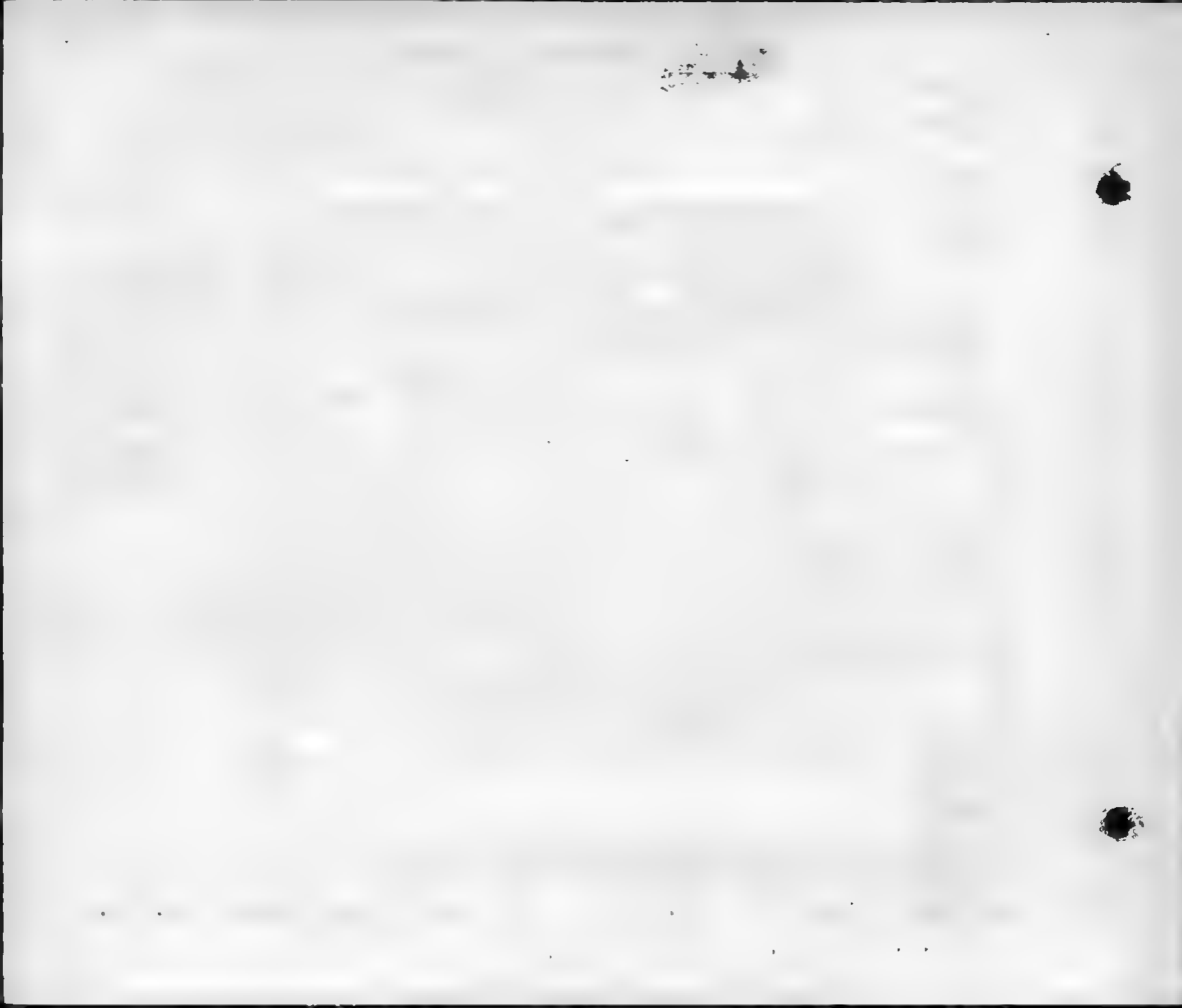


## 11484 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>  |  |   |  | c. LENGTH OF STAY IN TB <b>7 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>  |  |  |  |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | g. STREET ADDRESS <b>3815 YUMA STREET N.W.</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>THALES</b> Middle <b>BOWEN</b> Last <b>BOWEN</b>   |  |   |  | 4. DATE OF DEATH Month <b>OCT.</b> Day <b>15</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>8/5/85</b>             |  |
| 9. AGE (In years last birthday) <b>73 yrs.</b>  |  | 10. IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b> Hours <b>15</b> Min <b>58</b> |  | 11. IF UNDER 24 HRS. Months <b>7</b> Days <b>3</b> Hours <b>15</b> Min <b>58</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>THOMAS I. BOWEN</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>ANNIE BELLE BOWEN</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO <b>NONE</b>   |  |  |  |
| 17. INFORMANT <b>Dr. Thales Bowen Jr.</b>   |  |   |  | Address <b>405 Parkview Dr. Wynnwood, Pa.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Trauma, terminal</b>   |  |   |  |  |  |  |  |
| 420.1 DUE TO <b>hepato sclerosis</b>  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior sclerosis, generalized</b>   |  |   |  |  |  |  |  |
| (c) <b>Myocardial Infarction, posterior lateral wall 7 days old</b>   |  |   |  |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction, posterior lateral wall 7 days old</b>                                      |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month <b>Oct</b> Day <b>15</b> Year <b>19 58</b>  |  |   |  |  |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)   |  |   |  |  |  |  |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>1955 to Oct 15 1958</b> , that I last saw the deceased alive on <b>Oct 15 19 58</b> , and that death occurred at <b>10:15 A.M.</b> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| ADDRESS (Street, city or town, state) <b>3921 Ingomar St. Wash D.C.</b>   |  |   |  |  |  |  |  |
| DATE SIGNED <b>Oct 15 1958</b>  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.  |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |   |  |  |  |  |  |
| 22b. DATE THEREOF <b>10/18/58</b>   |  |   |  |  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery Prince Georges Co. Md.</b>   |  |   |  |  |  |  |  |
| 22d. LOCATION (City, town, or county) (State)   |  |   |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>  |  |   |  |  |  |  |  |
| ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>  |  |   |  |  |  |  |  |
| 24a. REC'D BY REGISTRAR <b>DATE OCT 17 58</b>   |  |   |  |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Wm. S. Threlk</b>   |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

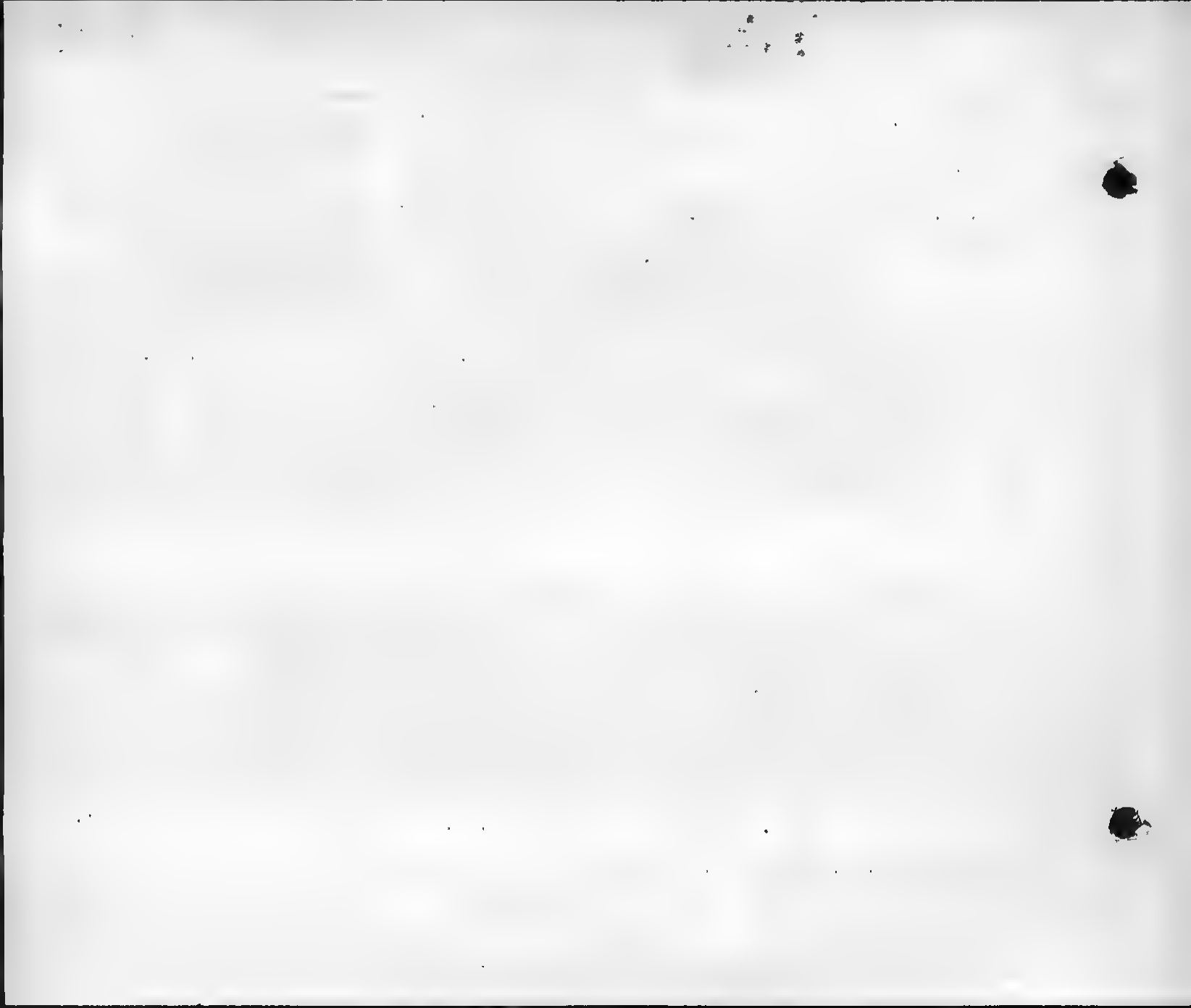
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**11485** CERTIFICATE OF DEATH

11454

Reg. Dist. No. 215

|  |                           |   |   |  |   |   |   |
|--|---------------------------|---|---|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br>Montgomery MARYLAND   |                           |   |   | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br>Virginia b. COUNTY |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |                           | c. LENGTH OF STAY IN 1b<br>38 days  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Alexandria                       |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. Naval Hospital, NNMHC  |                           |   |   | d. STREET ADDRESS<br>403 Cambridge Road  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br>Ellen Fouts BOWMAN  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>October 15 1958 |  |   |   |   |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>8-1-15                            |  | 9. AGE (In years last birthday)<br>43 yrs | IF UNDER 1 YEAR<br>Months Days Hours M n  | IF UNDER 24 HRS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - -  |   | 11. BIRTHPLACE (State or foreign country)<br>Florida   |   | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |   |
| 13. FATHER'S NAME<br>Edwin Lewis FOUTS   |                           |   |   | 14. MOTHER'S MAIDEN NAME<br>Mary DENHAM  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO<br>None  |   | 17. INFORMANT<br>(Husb) George S. Bowman, same as #2 above   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u><br>1972 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinoma of section and</u><br>DUE TO<br>(c) <u>Carcinoma of breast</u> |                           |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from September 8, 1958, to October 15, 1958, that I last saw the deceased alive on October 14, 1958, and that death occurred at 5:25A M, from the causes and on the date stated above.  |                           |   |   |  |   |   |   |
| ACTUAL SIGNATURE<br>M. G. Mitts  |                           | M D   |   | ADDRESS (Street, city or town, state)<br>U. S. Naval Hospital, NNMHC   |   | DATE SIGNED<br>10-15-58   |   |
| PHYSICIAN'S NAME (Type)<br>M. G. MITTS, LT, MC, USN  |                           | Bethesda 14, Maryland   |   |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>10-17-58   |   | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington National   |   | 22d. LOCATION (City, town, or county) (State)<br>Arlington Virginia                               |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Cunningham Funeral Home, Cameron & Alfred Sts.,  |                           |   |   | 24a. REC'D BY REGISTRAR<br>DATE OCT 16 '58   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Knaus   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11486

## CERTIFICATE OF DEATH

11455

Reg. Dist. No.

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GEN. WASHINGTON-ARCADE HOSPITAL</u>  |                                   | d. STREET ADDRESS <u>2501 GUE ST. N.W.</u>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Viola BOYLAND</u>  |                                   | 4. DATE OF DEATH Month Day Year <u>OCT. 24 1958</u>  |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 3, 1875</u> 9. AGE (In years last birthday) <u>83</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PA.</u>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>P. H. WILKINSON</u>   |                                   | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>Records at Nursing Home-Kensington, Md.</u>   |                                   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis (with small multiple thromboses)</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>May 25, 1958</u> , to <u>Oct. 24, 1958</u> , that I last saw the deceased alive on <u>Oct 19, 1958</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <u>Warner D. Brill, M.D.</u>  |                                   | ADDRESS (Street, city or town, State) <u>2601-16 St. N.W. Wash. D.C.</u> DATE SIGNED <u>Oct 24, 1958</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Warner D. Brill, M.D.</u>   |                                   | <u>Washington D.C.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 22b. DATE THEREOF <u>10/27/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Peace Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Thompson</u>   |                                   | ADDRESS <u>Washington D.C.</u>   |   |
| 24a. REC'D BY REGISTRAR <u>Oct 27 '58</u>  |                                   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>   |   |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11487

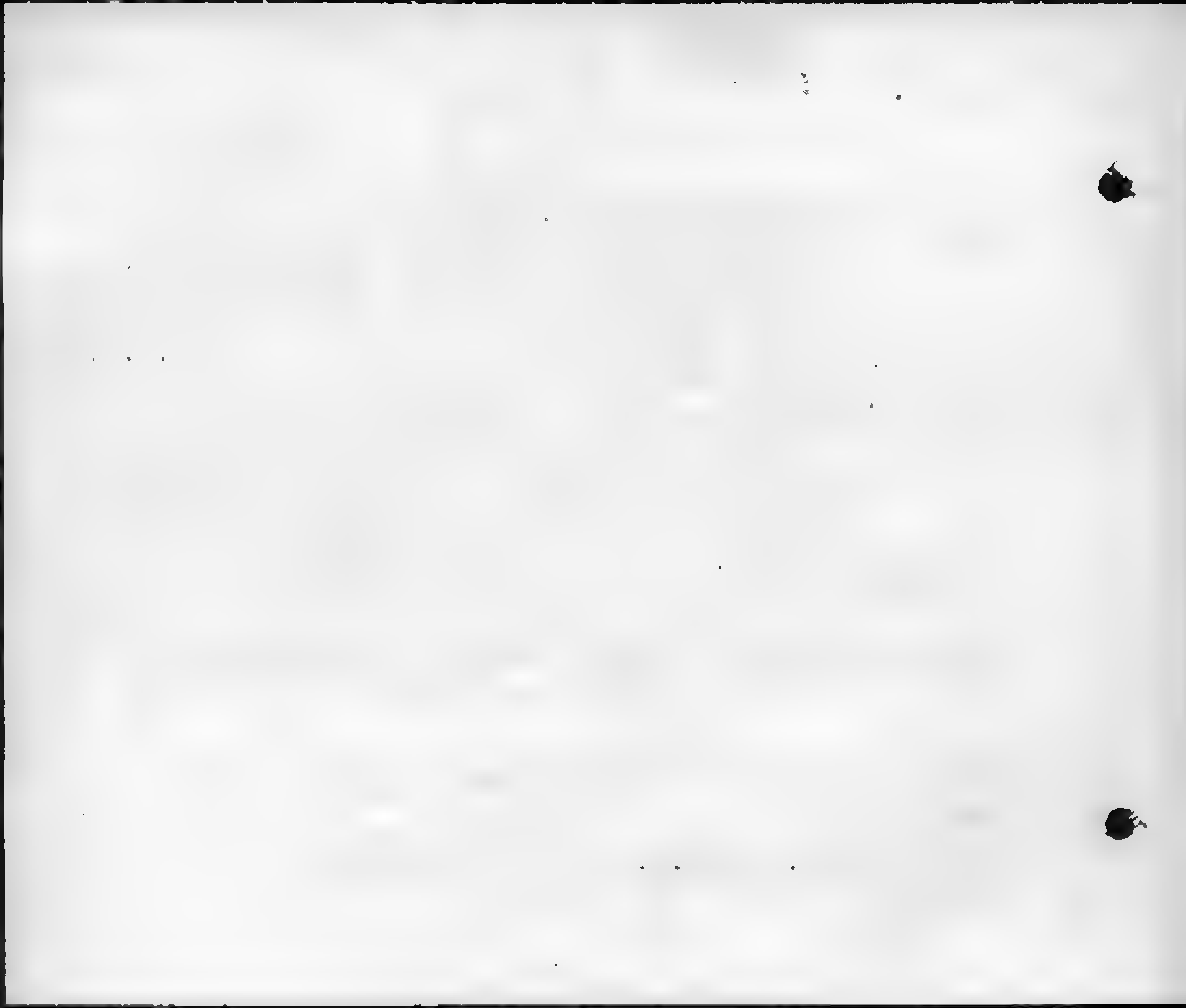
## CERTIFICATE OF DEATH

Reg. Dist. No. 11456

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Florida</u><br>b. COUNTY                               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>69 days</u>   |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hollywood</u>   |  |   |  | d. STREET ADDRESS<br><u>2622 Sherman Street</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><u>The Clinical Center, Bethesda 14, Md.</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Gordon</u> Middle <u>Bell</u> Last <u>Bradley</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>20</u> , Year <u>1958</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>February 3, 1883</u>   |  |
| 9. AGE (In years last birthday)<br><u>75</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Photographer</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Photography</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Indiana</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>Joseph S. Bradley</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Landora Bell</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>Unascertainable</u>   |  | 17. INFORMANT<br><u>The Medical Record Address</u><br><u>The Clinical Center, Bethesda 14, Maryland</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>STAPHYLOCOCCAL SEPTICEMIA</u>   |  |   |  |   |  |   |  |
| 154X DUE TO <u>THROMBOPHLEBITIS OF RT LEG</u>  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CANCER OF THE RECTUM</u>  |  |   |  |   |  |   |  |
| (c) <u>GENERALIZED METASTASIS</u>  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                  |  |
| 20f. (City or town)  |  | (County)  |  | (State)   |  |   |  |
| 21. I certify that I attended the deceased from <u>August 12, 1958</u> , to <u>October 20, 1958</u> , that I last saw the deceased alive on <u>October 20, 1958</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above |  |   |  |   |  |   |  |
| ADDRESS (Street, city or town, state)<br><u>The Clinical Center</u>  |  |   |  | DATE SIGNED<br><u>10/21/58</u>  |  |   |  |
| ACTUAL SIGNATURE<br><u>James M. Marsh, M. D.</u>   |  |   |  | NATIONAL INSTITUTES OF HEALTH<br><u>Bethesda 14, Maryland</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |  | 22b. DATE THEREOF<br><u>10-21-58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Lees Crematorium</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Washington D.C.</u>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. Wm Lewis Sons Co. 300-4th St N.E.</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 23 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles E. Kneass</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11457

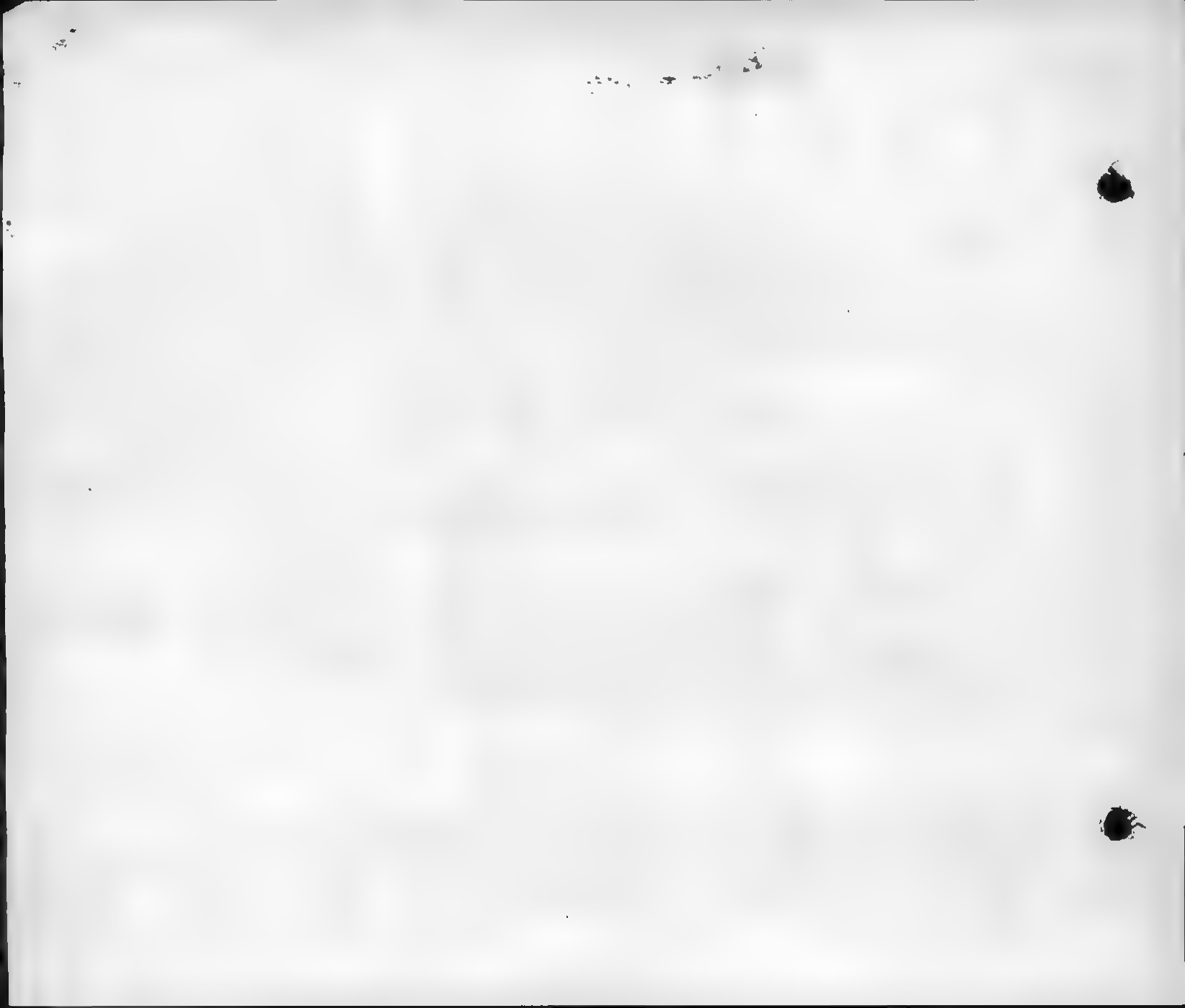
11488

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |                               |  |                                  |
|---|-------------------------------|--|----------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>montg</u>                        |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Silver Spring</u>   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4612 Coakway Dr.</u>  |                               | d. STREET ADDRESS <u>4612 Coakway Dr.</u>  |                                  |
| 3. NAME OF DECEASED (Type or print) <u>Katherine Cecelia Bready</u>   |                               | 4. DATE OF DEATH <u>10-19-58</u> 19  |                                  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-17-90</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs.  |                               | 10. IF UNDER 1 YEAR <u>10-19-58</u> Months Days Hours Min  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME <u>Eugene Sullivan</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>ANNA MULVIHILL</u>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO   |                                  |
| 17. INFORMANT <u>Margaret Gore - Same as Item 2</u>   |                               | Address  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)  |                               |  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>   |                               |  |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>  |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               | DATE SIGNED <u>10-19-58</u>  |                                  |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>10-23-58</u>  |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Maryland</u>  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins 3821-14th N.W. Wash. D.C.</u>   |                               | 24a. RECEIVED BY REGISTRAR <u>DATE 21 '58</u>  |                                  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>   |                               |  |                                  |

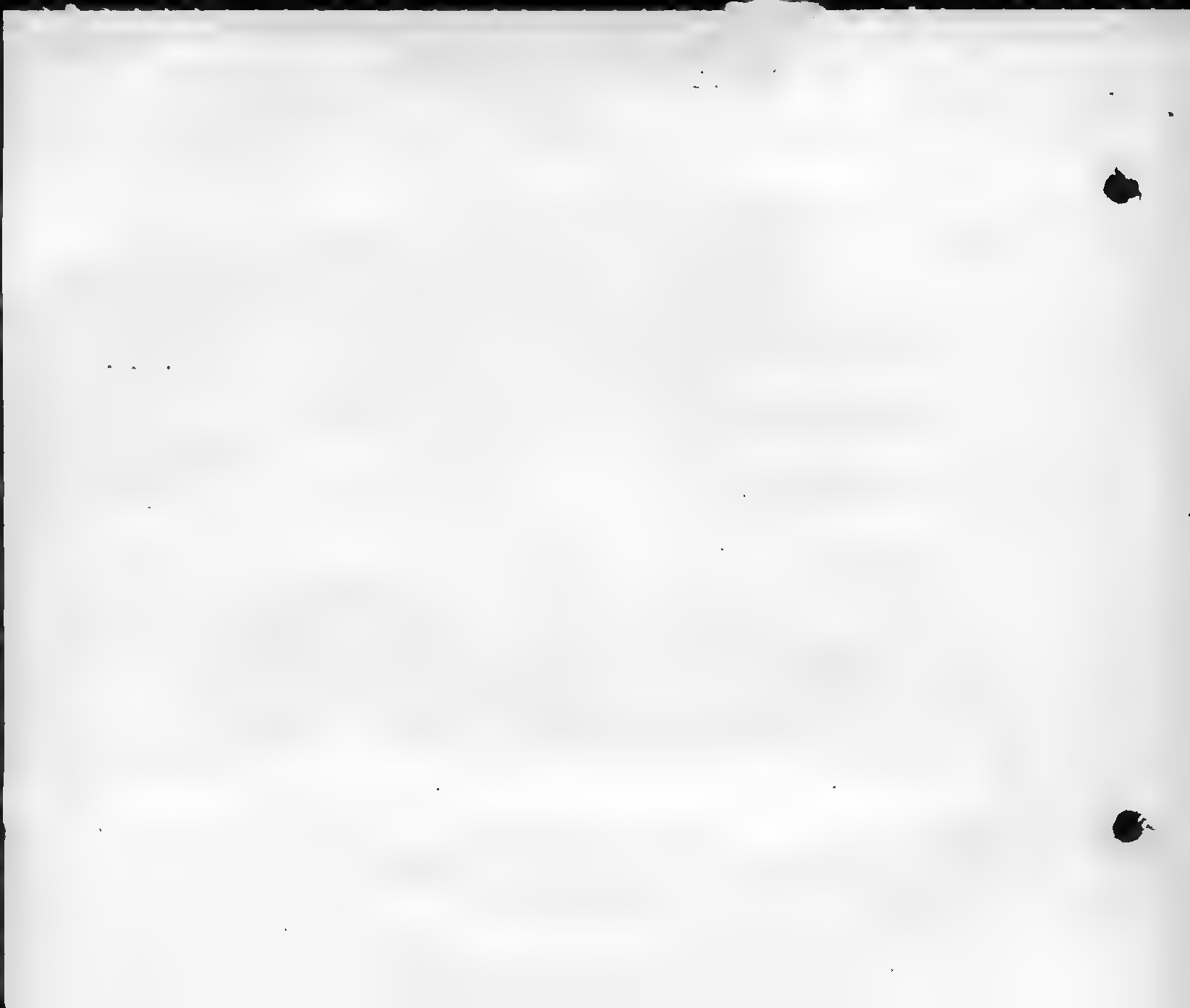
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No.

|   |                                  |   |   |  |   |   |  |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived - If inst. put on Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>18 days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   | d. STREET ADDRESS<br><b>14 Williams St.</b>                                 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Montgomery County General Hospital</b>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nicholas</b> Middle <b>---</b> Last <b>Brewer</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>20</b> Year <b>19 58</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/21/84</b>                  | 9. AGE (In years last birthday)<br><b>74</b> yes   | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>29</b> | IF UNDER 24 HRS<br>Hours <b>---</b> Min <b>---</b>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Financiere</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dunn and Bradstreet</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>                              |  |
| 13. FATHER'S NAME<br><b>John B. Brewer</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Russell</b> |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT<br><b>Hospital Records</b>   |   | Address<br><b>Olney, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b><br>DUE TO <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diaphragmatic Rupture - 4 days post-operative</b> |                                  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>11</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Hour <b>---</b> o. m. <b>---</b> p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>10/15</b> , 19 <b>58</b> , to <b>10/20</b> , 19 <b>58</b> that I last saw the deceased alive on <b>10/19</b> , 19 <b>58</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.  |                                  |   |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Arthur F. Woodward</b> M.D.   |                                  |   |   | ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>10/22/58</b>  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>A. F. Woodward, M. D.</b>  |                                  |   |   | <b>Rockville, Maryland</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/22/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>DACT 22 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>                        |  |

VS A15 (4)  
ISM 10/57



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

Items 20&21 Film 252 10-22-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11459

11490

Reg. Dist. No.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. LENGTH OF STAY IN IL <u>D.O.A.</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If inst. tuition, Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  |  |  | e. IS DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Henry Hermann Buckholtz</u>  |  | 4. DATE OF DEATH <u>October 12, 1958</u>   |  | 5. SEX <u>Male</u>  |  |
| 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept. 3, 1900</u>   |  |
| 9. AGE (In years last birthday) <u>58</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 13. FATHER'S NAME <u>Henry Hermann Theodore Buckholtz</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Wilhemina Buckholtz</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW I</u>   |  | 16. SOCIAL SECURITY NO <u>Unknown</u>  |  | 17. INFORMANT <u>Margaret A. Buckholtz</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO <u>Carbon monoxide poisoning</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u><br>DUE TO (c) <u>Carbon monoxide poisoning</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Hose attached to exhaust extending in car</u>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u><br>Hour <u>10</u> a. m. p. m.  |  | 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                 |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |  |
| 20f. (City or town) <u>Glen Echo Hts. Montg. Md.</u>  |  | (County) (State)   |  |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED <u>10-12-58</u>   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |  | 22b. DATE THEREOF <u>10/16/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>  |  |
| 22d. LOCATION (City, town, or county) <u>Fr. Myer</u>   |  | (State) <u>Pa</u>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>   |  | ADDRESS <u>3012 M. ST. N.W. Wash. D.C.</u>   |  | 24a. REC'D BY REGISTRAR <u>ACT 14 '58</u>   |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Huns</u>   |  |





11491 CERTIFICATE OF DEATH

Reg. Dist. No. 11460

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MARYLAND</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>o STATE <u>Bethesda</u> b. COUNTY <u>Bethesda</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |  |  | c. LENGTH OF STAY IN 1b  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Bethesda Hospital</u>  |  |  |  | d. STREET ADDRESS<br><u>120 Cedar Grove</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Infant Boy</u> First <u>Boy</u> Middle <u>Butler</u> Last <u>Butler</u>   |  |  |  | 4. DATE OF DEATH <u>Oct 13</u> 19 <u>55</u> Month <u>Oct</u> Day <u>13</u> Year <u>1955</u>  |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>W.C.</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Oct 8</u> 19 <u>58</u>                                     |  |
| 9. AGE (In years lost birthday) yrs <u>5</u>   |  | IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u> |  | IF UNDER 24 HRS  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>11224 9th St</u>               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>ROBERT NEIL BUTLER</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Diana Thelma McLaughlin</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT<br><u>MOTHER</u> Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEGMENTAL ATELECTASIS</u>   |  |  |  |  |  |  |  |
| 762.5 DUE TO (b) <u>PREMATURITY</u>  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY Month. Day. Year<br>Hour o m p m 19  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  |
| 20f. (City or town)  |  |  |  | (County)   |  | (State)  |  |
| 21. I certify that I attended the deceased from <u>October 8</u> , 19 <u>58</u> to <u>October 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 13</u> , 19 <u>58</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above |  |  |  |  |  |  |  |
| ADDRESS (Street, city or town, state)  |  |  |  | DATE SIGNED <u>OCT 13 1958</u>   |  |  |  |
| ACTUAL SIGNATURE <u>Ira W. Pearlman</u> M.D.   |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Ira W. Pearlman -4700 Bradley Blvd.-Chevy Chase.Md.</u>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>10/21/58</u>                                       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Oak</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Gaithersburg, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-Bethesda, Md.</u>  |  |  |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 22 '58</u>                              |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Huns</u>  |  |  |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11492 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>M.</b>                       |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Suburban Hospital</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Suburban Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>4212 Brookfield Drive</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>James Ellsworth Butler</b>  |  |   |  | 4. DATE OF DEATH <b>October 24 19 58</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 28, 1911</b>                                    |  |
| 9. AGE (In years lost birthday)<br><b>47</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>26</b> Hours <b></b> Min <b></b> |  | IF UNDER 24 HRS<br>Months <b></b> Days <b></b> Hours <b></b> Min <b></b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sheet Metal worker</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sheet Metal Ind.</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Joseph A. Butler</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Isabel <del>RAVE</del> Weaver</b>  |  |   |  |
| 15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>World War II</b>  |  |   |  | 16. SOCIAL SECURITY NO<br><b>Unknown</b>  |  |   |  |
| 17. INFORMANT<br><b>Rita Eleanor Butler--Wife--same</b>  |  |   |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery disease</b><br><b>141.9</b> DUE TO <b>following myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial infarction</b><br>(c) <b>Myocardial infarction</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b></b> a. m. <b></b> p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>10/24 1958</b> to <b>10/24 1958</b> , that I last saw the deceased alive on <b>10/24 1958</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Frederick Y. Dorn</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>1835 E St., N.W. Washington, D.C.</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Frederick Y. Dorn, M.D.</b>   |  |   |  | DATE SIGNED <b>10/24/58</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/28/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |   |  | ADDRESS<br><b>Bethesda, Maryland</b>  |  |   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 58</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. HARRIS</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11493 CERTIFICATE OF DEATH

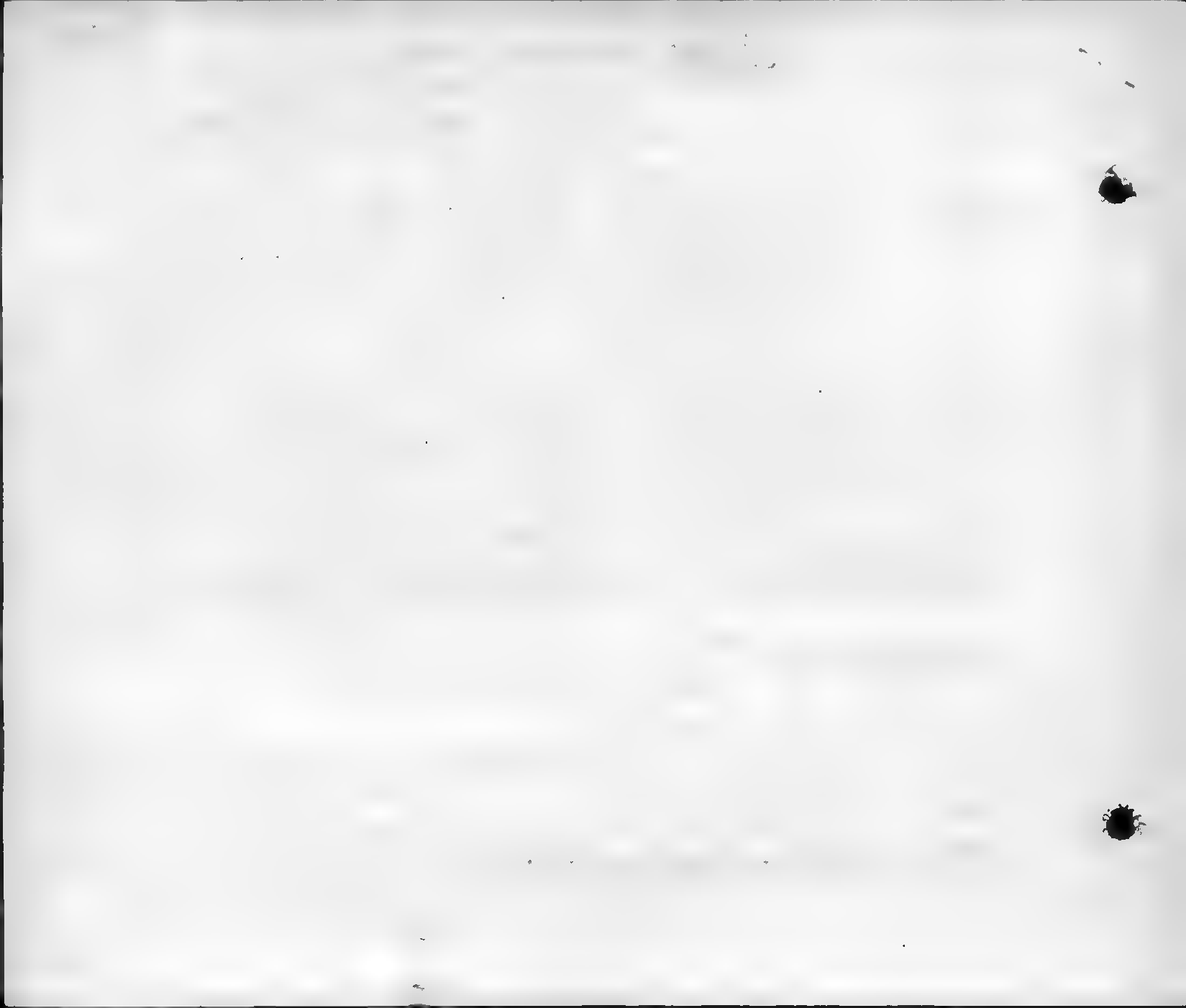
11462

Reg. Dist. No.

|   |                               |  |                                       |  |   |  |  |
|---|-------------------------------|--|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |                               |  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Suburban Hospital</b>  |                               |  |                                       | d. STREET ADDRESS <b>4709 S. Chelsea Lane</b>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>LINDA</b> First <b>ARLINE</b> Middle <b>BUTLER</b> Last  |                               |  |                                       | 4. DATE OF DEATH <b>Oct. 4,</b> 19 <b>58</b> Month <b>Oct.</b> Day <b>4</b> Year <b>58</b>   |   |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Jan. 30, 1949</b> | 9. AGE (In years last birthday) <b>9</b> yrs   | IF UNDER 1 YEAR <b>8</b> Months <b>4</b> Days | IF UNDER 24 HRS <b>Hours</b> <b>Min.</b>                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>  |                                       | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                  |  |
| 13. FATHER'S NAME <b>Benjamin T. Butler</b>   |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <b>Donna Williams</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                       | 17. INFORMANT <b>Benjamin T. Butler - Item # 2</b> Address   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Albright's Disease</b><br>DUE TO<br>(c) |                               |  |                                       |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>2-3 mos.</b><br><b>From birth</b>    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |  |                                       |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour o. m. p. m.  |                               |  |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
|   |                               |  |                                       | 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <b>9/29</b> 19 <b>58</b> , to <b>10/4</b> 19 <b>58</b> , that I last saw the deceased alive on <b>10/3</b> 19 <b>58</b> , and that death occurred at <b>5:10 A.M.</b> from the causes and on the date stated above.   |                               |  |                                       |  |   |  |  |
| ADDRESS (Street, city or town, state)   |                               |  |                                       | DATE SIGNED  |   |  |  |
| ACTUAL SIGNATURE <b>Vincent L. O'Donnell</b> M.D.   |                               |  |                                       | <b>8218 - Wise Ave Bethesda Md</b>   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Vincent L. O'Donnell, M. D.</b>  |                               |  |                                       |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>10/6/58</b>   |                                       | 22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>   |   | 22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b> ADDRESS   |                               |  |                                       | 24a. REC'D BY REGISTRAR <b>OCT 7 '58</b> DATE  |   | 24b. REGISTRAR'S SIGNATURE <b>Wm S. Kraus</b>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11494

## CERTIFICATE OF DEATH

11463

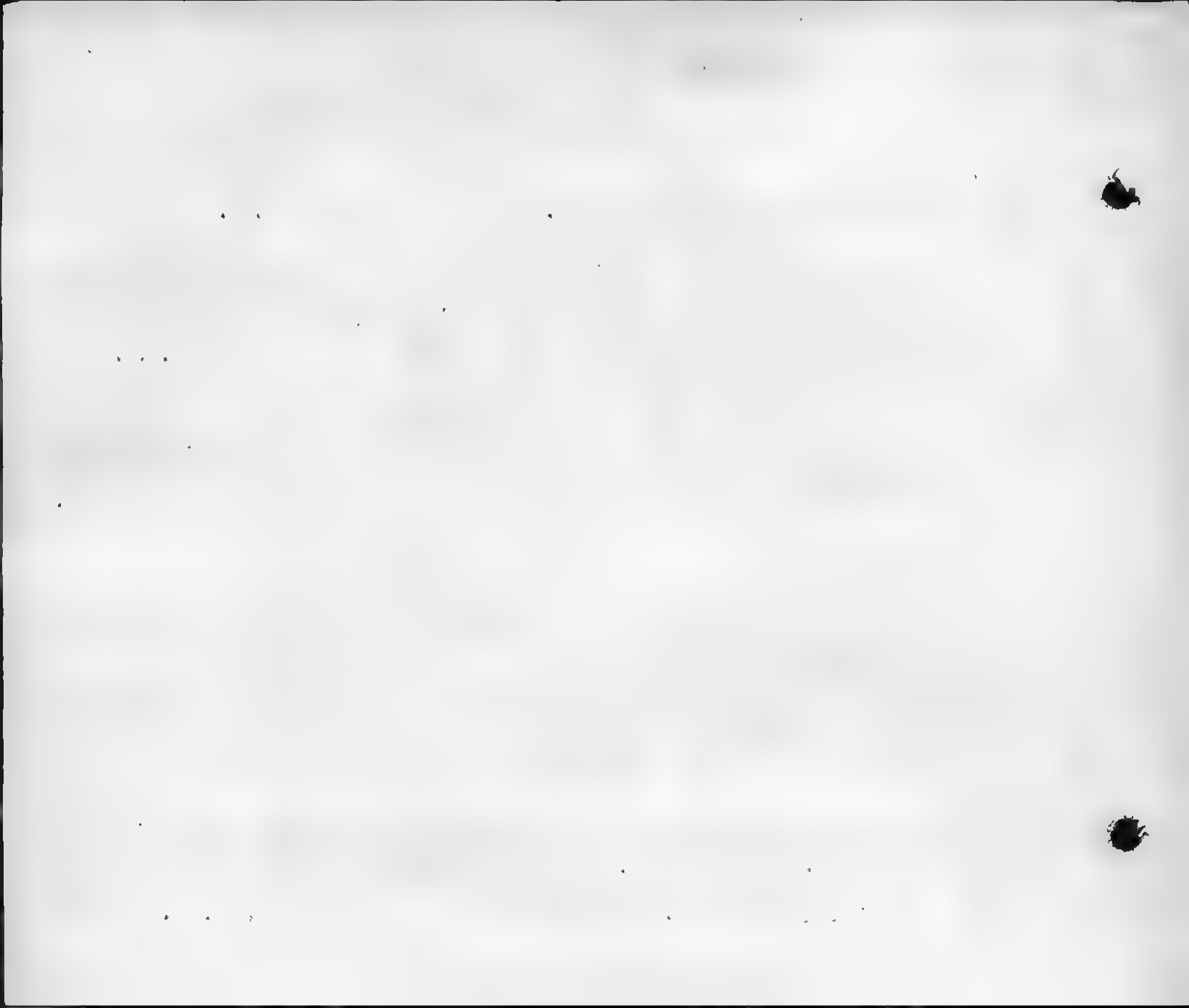
Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived if institut on Res dence before admiss on)<br>a. STATE<br><b>District of Columbia</b><br>COUNTY                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>9 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Florence Genevieve Cassidy</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 31 19 58</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 14, 1888</b>  |
| 9. AGE (In years last birthday) yrs<br><b>70</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dance Instructor</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Musical</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Bradford McMichael</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hass</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>None</b>   |   |
| 17. INFORMANT<br><b>The Medical Record</b>   |                                  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b><br><b>570.5</b> DUE TO<br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <b>fibrous adhesions</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital Heart Disease--atrial septal defect</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs.</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      |
| 20f. (City or town)<br><b>Washington</b>   |                                  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>October 22, 1958</b> , to <b>October 31, 1958</b> , that I last saw the deceased alive on <b>October 31, 1958</b> , and that death occurred at <b>12:46 P.M.</b> from the causes and on the date stated above<br><b>12:46 a.m.</b> ADDRESS (Street, city or town, state) DATE SIGNED<br><b>10-31-58</b>   |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Leon I. Goldberg</b>  |                                  | M.D. <b>The Clinical Center</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Leon I. Goldberg, M.D.</b>   |                                  | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>  |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>11-3-1958</b>   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Dowling Jones, Wash. D.C.</b>  |                                  | ADDRESS<br><b>Wash. D.C.</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 5 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Curt S. Fraser</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

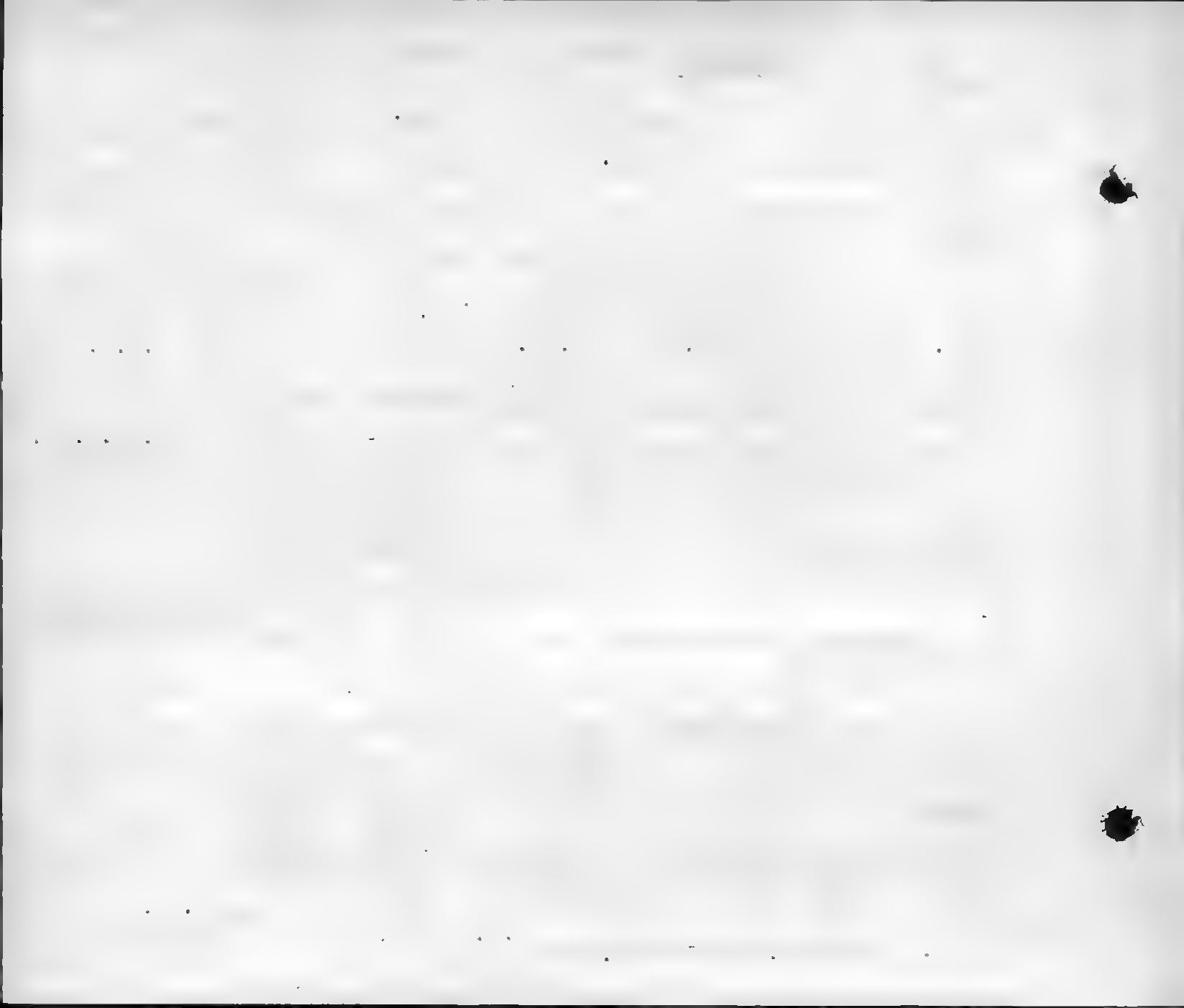
11455

CERTIFICATE OF DEATH

Reg. Dist. No. 11464

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>o STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>18 mo.</b>   |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |   |  | d. STREET ADDRESS<br><b>8007 Takoma Avenue</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>8007 Takoma Avenue</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alonzo</b> Middle <b>John</b> Last <b>Chadsey</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>4</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 1, 1872</b>   |  |
| 9. AGE (In years lost birthday)<br><b>86</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b> |  | IF UNDER 24 HRS.<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Exec. Secretary</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Met. Life Ins. Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Alonzo John Chadsey</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Emily Palmer</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or date of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Beatrice Kelly-8007 Takoma Ave. S.S.Md.</b>                               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma of Right Lung</b><br><b>162.1</b><br>with metastasis to liver<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>DUE TO</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>8801 Colosville Road</b> |  |
| 20f. (City or town)<br><b>Saugerties, N. Y.</b>   |  |   |  | 20g. (County)<br><b>Saugerties, N. Y.</b>  |  | 20h. (State)<br><b>N. Y.</b>  |  |
| 21. I certify that I attended the deceased from <b>August 1, 1958</b> to <b>October 4, 1958</b> , that I last saw the deceased alive on <b>October 1, 1958</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D.  |  |   |  | DATE SIGNED <b>October 4, 1958</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D. Silver Spring, Maryland</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>10/4/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Mountain</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Saugerties, N. Y.</b>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co. 2901 14th St. Washington</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 6 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>C. L. S. Hines</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

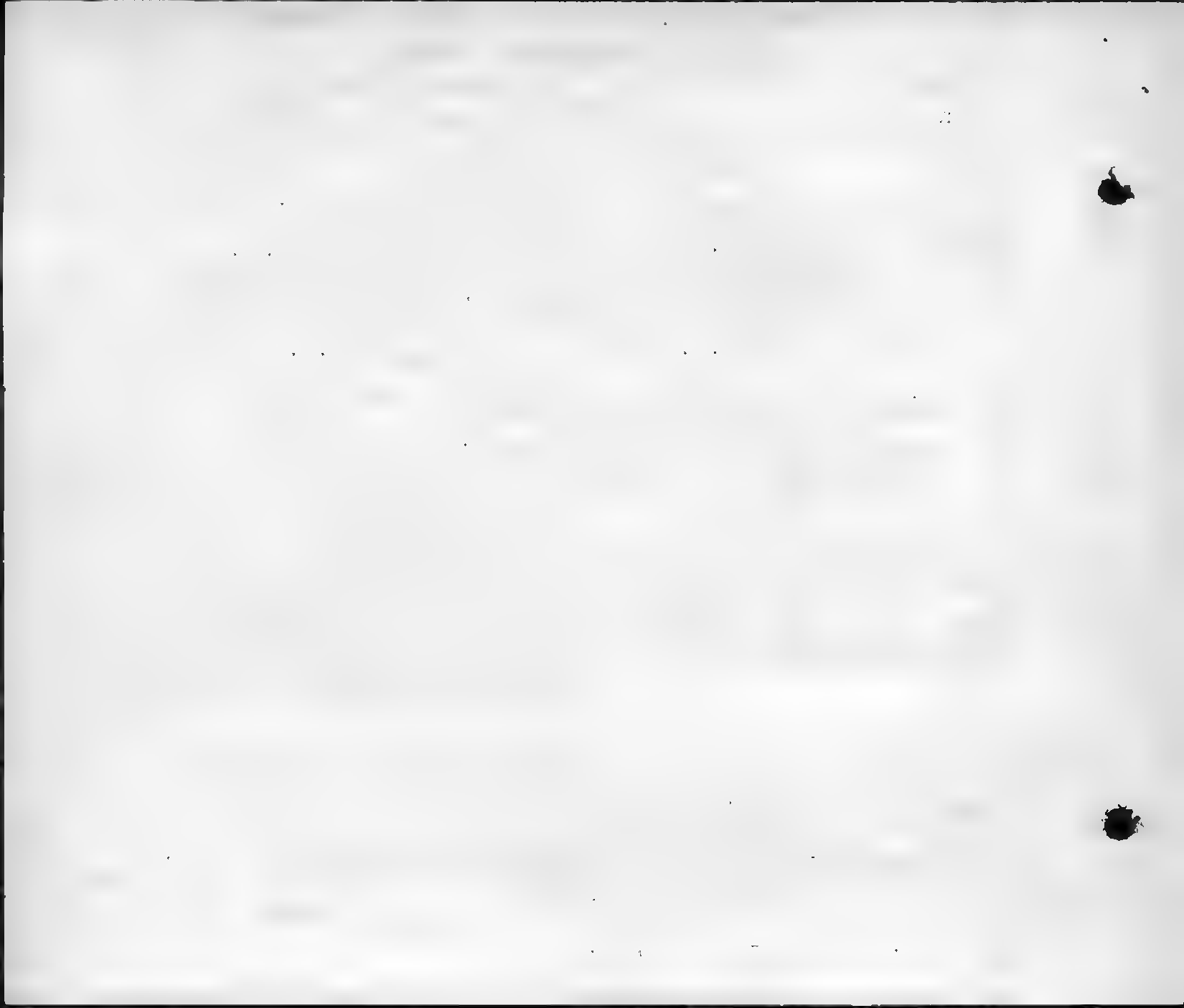
11465 CERTIFICATE OF DEATH

11465

Reg. Dist. No.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Rockville</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>11509 Danville Drive</b>  |                                  |   |   | d. STREET ADDRESS<br><b>11509 Danville Dr.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JOHN A. CLARK</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> , Day <b>8</b> , Year <b>19 58</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jne 10, 1898</b> | 9. AGE (In years last birthday)<br><b>60</b>   | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>28</b> Hours <b></b> Min <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bus Operator</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>D. C. Transit</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                                  | 13. FATHER'S NAME<br><b>John F. Clark</b>   |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Belle McCadden</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b> <b>WWI</b>   |   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>578-10-5574</b>   |                                  | 17. INFORMANT<br><b>Arline E. Clark-Item # 2</b>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis</b><br>DUE TO<br>(c) <b></b><br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension - known 4 years</b> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>known 15 months</b>                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town)   |                                  | 20g. (County)   |   | 20h. (State)   |   |
| 21. I certify that I attended the deceased from <b>3/3</b> , 19 <b>57</b> , to <b>Oct</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 24, 19 58</b> , and that death occurred at <b>9:45 PM</b> , from the causes and on the date stated above.<br><b>Allen J. O'Neill</b> ADDRESS (Street, city or town, state) DATE SIGNED   |                                  |   |   |  |   |
| ACTUAL SIGNATURE <b>Allen J. O'Neill</b> M.D.   |                                  |   |   |  |   |
| PHYSICIAN'S NAME (Type) <b>Allen J. O'Neill</b> 8601 Old Georgetown Road, Bethesda, Md.   |                                  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/10/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   |
| 22d. LOCATION (City, town, or county)   |                                  | 22e. (State)<br><b>Arlington, Virginia</b>  |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Wm. S. Frank</b>   |                                  |   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



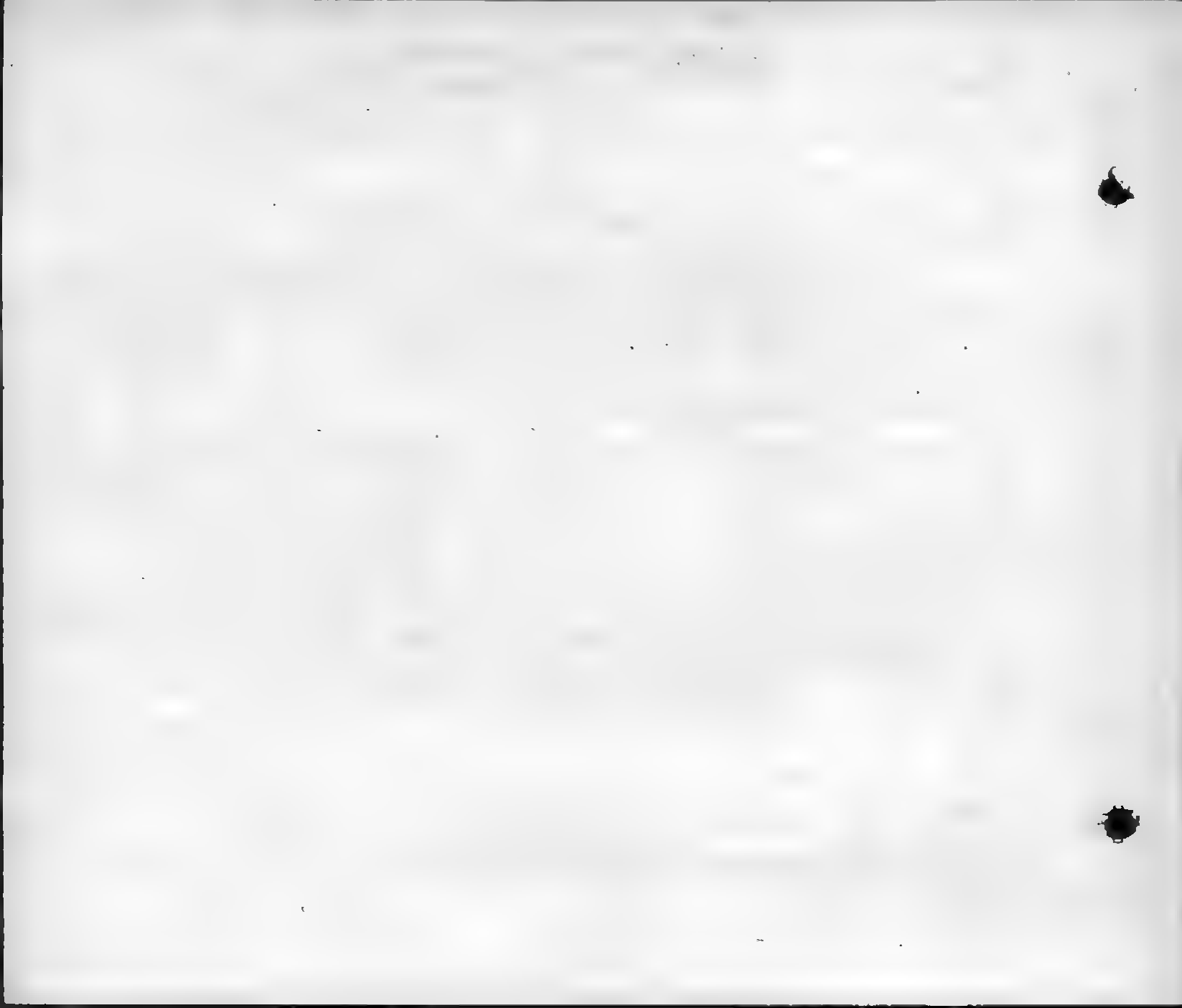
## 11496 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>o. STATE <b>WASH, D.C.</b> b. COUNTY                               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>8</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SUBURBAN</b>   |  |  |  | d. STREET ADDRESS<br><b>3726 JOCELYN ST., N. W.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>E</b> Last <b>COCHRANE</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>17</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>W</b>             |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5/28/85</b>   |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. -</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>US Govt.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Canada</b>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John E. Cochran</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Anne Walker</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U S ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>Address<br><b>Harriet H. Cochran-Item#2</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subendocardial Infarction, Left Ventricle</b>  |  |  |  |   |  |  |  |
| 420.1 DUE TO <b>Coronary Thrombosis, Left Artery Circumflex Artery</b> 24 hours   |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary Arteriosclerosis</b> years  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 19 WAS AUTOPSY PERFORMED?<br>1) <b>Gout, moderately severe</b> 2) <b>Myocardial Infarction</b> 1956 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street-office bldg., etc.)      |  |
| 20f. (City or town) <b>Wash D.C.</b>  |  |  |  | 20g. (County)   |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <b>1948</b> to <b>SEP 17</b> 1958; that I last saw the deceased alive on <b>SEP 17</b> 1958, and that death occurred at <b>1200 P.M.</b> from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Stewart Clapp</b>   |  |  |  | ADDRESS (Street, city or town, state) <b>3921 Ingomar SP NW Wash DC</b>   |  |  |  |
| DATE SIGNED <b>OCT 17 58</b>  |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>  |  |  |  | ADDRESS <b>Wash DC</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 22b. DATE THEREOF<br><b>10/20/58</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitlane, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Maryland</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 20 58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Wm S. Hume</b>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

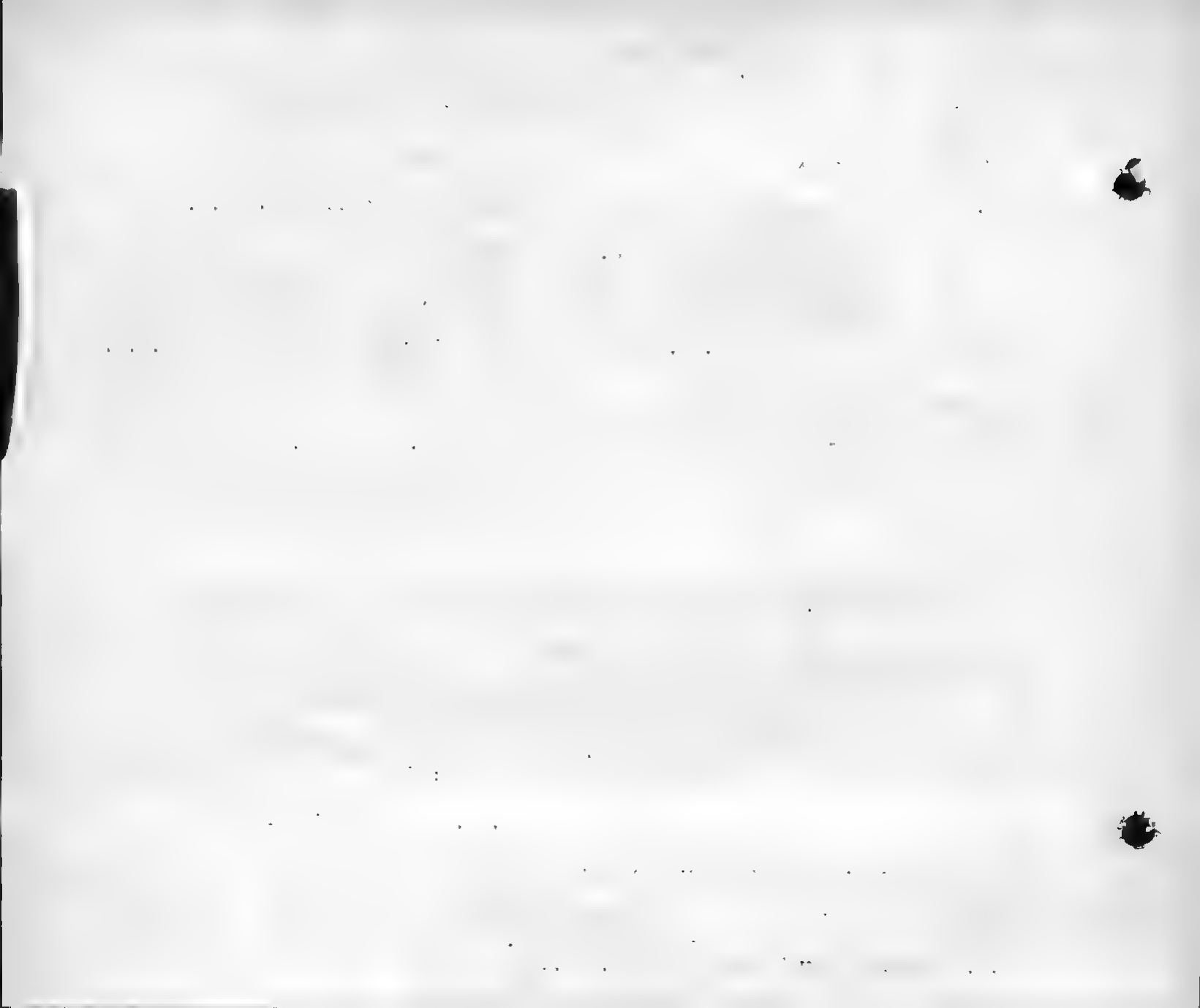
11497 CERTIFICATE OF DEATH

Reg. Dist. No.

11467  
215

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>36 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b><br>d. STREET ADDRESS<br><b>4000 Massachusetts Ave., N.W.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Claiborn</b><br>Middle<br><b>J.</b><br>Last<br><b>COCKRELL</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>29</b><br>Year<br><b>1958</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>April 30, 1900</b>   |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>5</b>  | 11. IF UNDER 24 HRS<br>Days<br><b>5</b><br>Hours<br><b>58</b><br>Min<br><b>58</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mariner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Navy</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>California</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Moses COCKRELL</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah OWENS</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes</b><br><b>WWI - WWII</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>547-36-6430</b>   |   |
| 17. INFORMANT<br><b>(W) Lucille M. Cockrell, same as #2 above</b><br>Address   |                                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>21X cerebral hemorrhage</b><br>DUE TO<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO<br>(c) <b>Unknown</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Myocardial infarction due to coronary thrombosis 5 weeks</b>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>5 weeks</b>   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. 19<br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Sept. 23, 1958</b> to <b>October 29, 1958</b> , that I lost saw the deceased alive on <b>October 29, 1958</b> , and that death occurred at <b>10:55P</b> M, from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>J. T. Horgan</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital, NNM</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>J. T. HORGAN, LCDR, MC, USN</b>  |                                  | DATE SIGNED<br><b>10-30-58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-4-58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. E. Pumphrey</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>NOV 3 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |                                  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 11441 CERTIFICATE OF DEATH

11468

Reg. Dist. No.

|   |                               |  |                                  |   |  |  |                  |
|---|-------------------------------|--|----------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                               |  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK, MD</b>   |                               |  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>  |  |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH LINGTON SANITARIUM + HOSPITAL</b>  |                               |  |                                  | d. STREET ADDRESS <b>3919 Kincaid Tr.</b>   |  |  |                  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                  |   |  |  |                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>Isabella FRANCES Cole</b>  |                               |  |                                  | 4. DATE OF DEATH Month Day Year <b>10 9 19 58</b>   |  |  |                  |
| 5. SEX <b>FE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10/26/25</b> | 9. AGE (In years last birthday) <b>32</b> yrs.  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b>  |                               |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Welfare</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Illinois</b>                        |                  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                               |  |                                  |   |  |  |                  |
| 13. FATHER'S NAME <b>Leo J. Gossman</b>   |                               |  |                                  | 14. MOTHER'S MAIDEN NAME <b>Gertrude Anderson</b>   |  |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |                               |  |                                  | 16. SOCIAL SECURITY NO. <b>357-18-2217</b>  |  | 17. INFORMATION <b>Hospital Records</b>  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>330x Cerebral hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>32 yrs</b><br>(c) <b>Congenital cerebral arterial aneurysmal rupture</b> |                               |  |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  |  |  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  |                               |  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                  |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>  |                               |  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |                  |
| 20f. (City or town) (County) (State)  |                               |  |                                  |   |  |  |                  |
| 21. I certify that I attended the deceased from <b>Oct. 7</b> , 19 <b>58</b> , to <b>Oct. 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct. 9</b> , 19 <b>58</b> , and that death occurred at <b>4</b> A. M. from the causes and on the date stated above  |                               |  |                                  |   |  |  |                  |
| ADDRESS (Street, city or town, state)   |                               |  |                                  | DATE SIGNED   |  |  |                  |
| ACTUAL SIGNATURE <b>Donald Nelson</b>   |                               |  |                                  | M. D. <b>10620 Georgia Ave., Silver Spring, Md.</b>   |  |  |                  |
| PHYSICIAN'S NAME (Type) <b>Donald Nelson</b>  |                               |  |                                  |   |  |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 22b. DATE THEREOF <b>10/13/58</b>  |                                  | 22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Ziska</b>  |                               |  |                                  | 24a. REC'D BY REGISTRAR DATE <b>OCT 14 58</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>James S. Thomas</b>                                |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11469

Reg. Dist. No.

11468

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |                                   |
|---|--|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                   |
| b. CITY OR TOWN <u>Bethesda</u> (If outside corporate limits, write RURAL and give nearest town)  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincoln Park-Rockville</u>   |                                   |
| c. LENGTH OF STAY IN TB <u>1 day</u>  |  | d. STREET ADDRESS <u>808 Stonestreet Ave.</u>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | e. IS SE. D.N. F. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Mabel</u>   | First <u>Mabel</u> Middle <u>Cook</u> Last <u>Cook</u> | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>9</u> Year <u>1958</u>  |                                   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>C</u>                              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-25-1917</u> |
| 9. AGE (In years last birthday) <u>41</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>10</u> Hours <u>9</u> Min. <u>1958</u>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |                                   |
| 13. FATHER'S NAME <u>Augustus Williams</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Lula Johnson</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>Husband William Cook</u>  |                                   |
| 17. INFORMANT <u>Husband William Cook</u>   |  | Address <u>William Cook</u>  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Edema</u><br>385X DUE TO (b) <u>Status Post Cardiac Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>7 hours</u><br><u>7 hours</u>   |  |  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supine position, cataract surgery, general anesthesia</u>  |  |  |                                   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o. m. <u>19</u> p. m.  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |                                   |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>  |  | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                   |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED <u>10-10-58</u>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-13-58</u>   |  | 22b. DATE THEREOF <u>10-13-58</u>  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sur. Rockville, Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>10-14-58</u>  |                                   |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Khand</u>   |  |  |                                   |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11499 CERTIFICATE OF DEATH

Reg. Dist. No.

11470

|  |                               |  |  |   |   |  |  |
|--|-------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |                               | c. LENGTH OF STAY IN TB <u>22 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9311 Wire Avenue</u>   |                               |  |  | d. STREET ADDRESS <u>9311 Wire Avenue</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>M.</u> Last <u>COYLE</u>   |                               |  |  | 4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1958</u>  |   |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 27, 1863</u> | 9. AGE (In years last birthday) <u>94</u> yrs.  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>London, England</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Henry James</u>   |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>Ruby Gledhill</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO <u>none</u>   |  | 17. INFORMANT Address <u>Mrs. Nora O'Leary, 9311 Wire Ave. S. S. Md.</u>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Senile heart failure</u><br><u>442x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u><br>DUE TO (c) <u>hypertension</u>                              |                               |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not white of work <input type="checkbox"/> of work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Sept 30</u> , 19 <u>58</u> , to <u>Oct 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>58</u> , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u>Oct 27, 1958</u> |                               |  |  |   |   |  |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>5/11/58</u>  |                               |  |  | PHYSICIAN'S NAME (Type) <u>Dr. J. Arthur Walters</u>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>  |                               | 22b. DATE THEREOF <u>Oct. 27, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Arthur Walters, 254 Carroll St NW DC</u>  |                               |  |  | 24a. REC'D BY REGISTRAR <u>Oct 27 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11500

## CERTIFICATE OF DEATH

11472

Reg. Dist. No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattstown</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Happiness Home Clarksburg Md.</b>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattstown</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Georgie</b> Middle <b>Carmin</b> Last <b>Darby</b>   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>20</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 26 1883</b>                                |
| 9. AGE (In years last birthday) yrs.<br><b>75</b>  |  | 10. IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Montgomery County Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Philip C. Dudrow</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Achsah A. Dudrow</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Byron E. Darby</b>   |  | Address<br><b>Hyattstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, basal, terminal</b><br><b>465X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary infarct, left lung</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b><br><b>2 months</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive &amp; arteriosclerotic heart disease, Old C.V.A.</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><b>none</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>February, 1955, to 10/20, 1958</b> , that I last saw the deceased alive on <b>10/20/58</b> , 19____, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Main Street</b> DATE SIGNED _____   |  |   |  |
| ACTUAL SIGNATURE <b>B. Meadors</b> M.D.  |  | NAME (Type) <b>Gilcin F. Meadors, M.D.</b> <b>Damascus, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-23-1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. L. Burdette, Hyattstown, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 22 58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

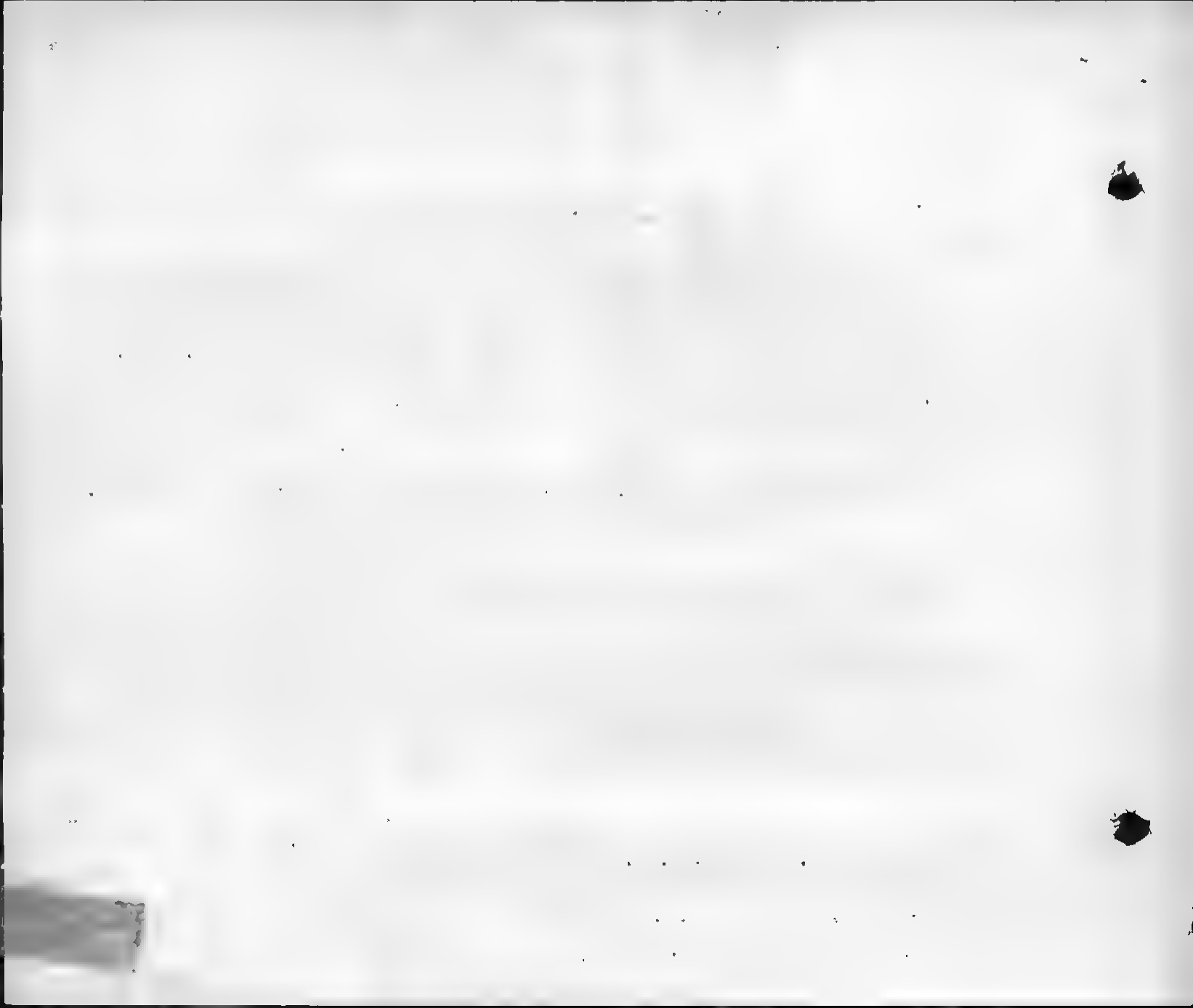
## 11501 CERTIFICATE OF DEATH

Reg. Dist. No. 11473

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda              |  | c. LENGTH OF STAY IN 1b<br>27 days   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br>Rhode Island |  | b. COUNTY   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>The Clinical Center, Bethesda 14, Md.  |  |   |  | e. STREET ADDRESS<br>6 Harrop Avenue   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>Phyllis Irene Deady   |  | First Middle Last   |  | 4. DATE OF DEATH<br>October 11, 1958   |  | Month Day Year  |  |   |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>March 16, 1950  |  | 9. AGE (In years last birthday)<br>8 yrs  |  |
| 10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |  | 11. BIRTHPLACE (State or foreign country)<br>Rhode Island  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  |
| 13. FATHER'S NAME<br>John F. Deady   |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Dorothy Clark  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>The Medical Record Address<br>The Clinical Center, Bethesda 14, Maryland  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br>Congenital Heart Disease: Atrial Septal defect (post operative)<br>DUE TO<br>Acute Atelectasis, bilateral<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO<br>(b)<br>(c) |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>8 yrs.<br>?   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County)<br>(State)  |  |   |  |
| 21. I certify that I attended the deceased from September 14, 1958, to October 11, 1958, that I last saw the deceased alive on October 11, 1958, and that death occurred at 7:45 P.M. from the causes and on the date stated above.  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>William P. Cornell   |  | M.D.  |  | ADDRESS (Street, city or town, state)<br>The Clinical Center<br>The National Institutes of Health<br>Bethesda 14, Maryland                               |  |   |  | DATE SIGNED<br>10-12-58   |  |
| PHYSICIAN'S NAME (Type)<br>William P. Cornell, M. D.   |  |   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial-Transit  |  | 22b. DATE THEREOF<br>10/13/58   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>S. S. Peter & Paul   |  | 22d. LOCATION (City, town, or county)<br>Coventry, Rhode Island (State)   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Robert A. Pumphrey-Bethesda, Maryland  |  |   |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE<br>OCT 14 58  |  | 24b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11502 CERTIFICATE OF DEATH

Reg. Dist. No. 11474

|  |                              |   |                                      |  |  |   |  |
|--|------------------------------|---|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>  |                              |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X Kensington</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>4108 Byeforde Court</u>   |                              |   |                                      | e. STREET ADDRESS<br><u>4108 Byeforde Court</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RICHARD</u> Middle <u>CAMPBELL</u> Last <u>DEAN</u>  |                              |   |                                      | 4. DATE OF DEATH<br>Month <u>OCT</u> Day <u>2</u> Year <u>1958</u>   |  |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/21/1901</u> | 9. AGE (In years last birthday)<br><u>57</u> yrs   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>11</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS<br>Hours <u></u> Min. <u></u>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sales Manager</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Sales</u>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>New York</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                  |  |
| 13. FATHER'S NAME<br><u>William C. Dean</u>  |                              |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Maude Egon</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>073-09-0332</u>   |                                      | 17. INFORMANT <u>815 Smith Street</u> Address<br><u>Mrs. Virginia Love-Salisbury, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF JAW AND NECK</u><br><u>199.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>   |                              |   |                                      |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2-17-22</u>                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                              |   |                                      |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              |   |                                      |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>19</u> o. m. <u></u> p. m. <u></u>  |                              |   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
|  |                              |   |                                      | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Jan 1</u> 19 <u>58</u> to <u>Oct 2</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 2</u> 19 <u>58</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <u>9400 Conn. Ave. Kensington, Md.</u> DATE SIGNED <u>10/2/58</u> |                              |   |                                      |  |  |   |  |
| ACTUAL SIGNATURE <u>John E. Egan</u>   |                              |   |                                      | M.D. <u>9400 Conn. Ave. Kensington, Md.</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>JOHN F. FIFARELLI</u>   |                              |   |                                      | <u>9400 Conn. Ave. Kensington, Md.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 22b. DATE THEREOF<br><u>10/4/58</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Rockville, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |                              |   |                                      | ADDRESS<br><u>Bethesda, Maryland</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 6 '58</u>                            |  |
|  |                              |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><u>Carlton S. Smith</u>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11442 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery County</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Tokoma Park 1</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Adelphi, Md.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Fairhill Nursing Home</b>  |  |   |  | d. STREET ADDRESS<br><b>2117 Rolander Street</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>ELIZABETH</b> Middle <b>DECK</b> Last  |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>1</b> Year <b>19 58-</b>  |  |  |  |
| 5 SEX<br><b>female</b>   |  | 6 COLOR OR RACE<br><b>white</b>   |  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>6/15/1888</b>  |  |
| 9 AGE (In years last birthday)<br><b>70</b> yrs  |  | IF UNDER 1 YEAR: Months Days Hours Min  |  | IF UNDER 24 HRS: Months Days Hours Min  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Drug Clerk</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 13. FATHER'S NAME<br><b>Unknown</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>                            |  | 16. SOCIAL SECURITY NO<br><b>no</b>   |  | 17. INFORMANT<br><b>Fairhill Nursing Home Tokoma Park, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>222 X</b><br>DUE TO <b>Cerebral Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Arteriosclerosis</b>          |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b><br><b>5 years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> o. m. p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Sept 11</b> , 19 <b>58</b> , to <b>Oct 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 10</b> , 19 <b>58</b> , and that death occurred at <b>8</b> <sup>PM</sup> AM, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>10-1-58</b> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>J. R. Raedy M.D.</b>   |  |   |  | PHYSICIAN'S NAME (Type) <b>J. R. Raedy M.D.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>   |  | 22b. DATE THEREOF<br><b>Oct 4, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Masoleum</b>  |  | 22d. LOCATION (City town or county) (State)<br><b>Suitland, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons Hyattsville, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 6 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Colbert S. House</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death

11. 6M

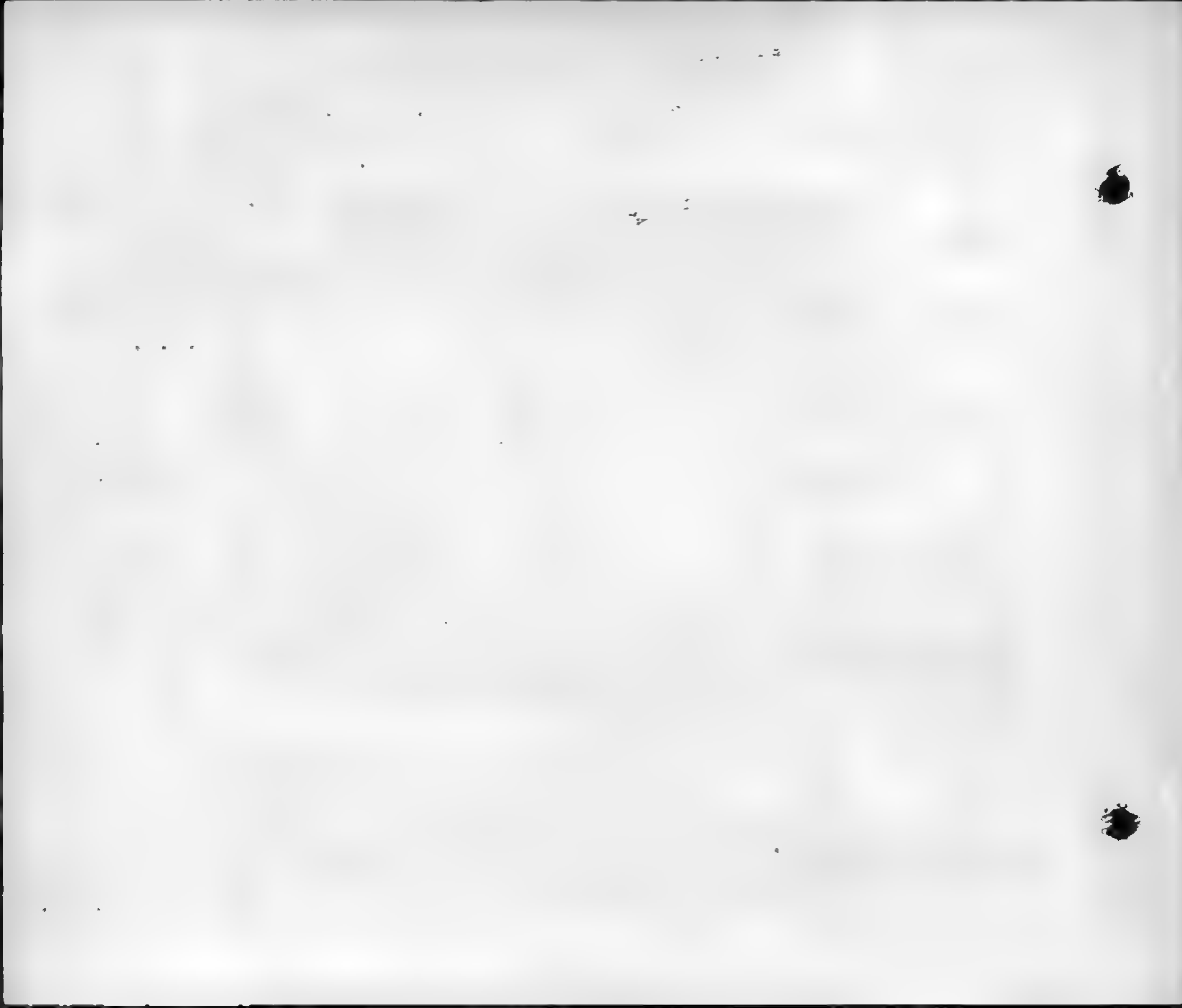
## 11503 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Dist. of Col.</u> b. COUNTY                         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>1 week</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Suburban Hospital</u>  |  |   |  | d. STREET ADDRESS<br><u>1722 Kenyon Street, N.W.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>(Leon)</u> Middle <u>John</u> Last <u>Dracopoulos</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>8</u> Year <u>19 58</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>March 15, 1888</u>   |  |
| 9. AGE (In years last birthday)<br><u>70</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Greece</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Restaurant owner</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Restaurant</u>   |  |   |  |
| 13. FATHER'S NAME<br><u>John Dracopoulos</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Caliope Roupas</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Brother John I. Dracopoulos</u>                               |  |
|   |  |   |  |  |  | Address <u>1722 Kenyon St., Washington, D.C.</u>                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u><br>DUE TO <u>Portal Vein Embolism</u> <u>24 hours</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mesenteric Venous Thrombosis</u> <u>48 hours</u><br>DUE TO (c) <u>Gastrointestinal Hemorrhage due to gastric Ulcers</u> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |  |
|   |  |   |  | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>10-1</u> 19 <u>58</u> to <u>10-8</u> 19 <u>58</u> , that I lost saw the deceased alive on <u>10-7</u> 19 <u>58</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Philip R. James</u>   |  |   |  | MD <u>Washington, D.C.</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Philip R. James</u>  |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>10/11/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   |  | 22d. LOCATION (City, town or county) (State)<br><u>Prince Georges County, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>S.H. Harris Co 2901-14th St. N.W.</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 9 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Harris</u>                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11504

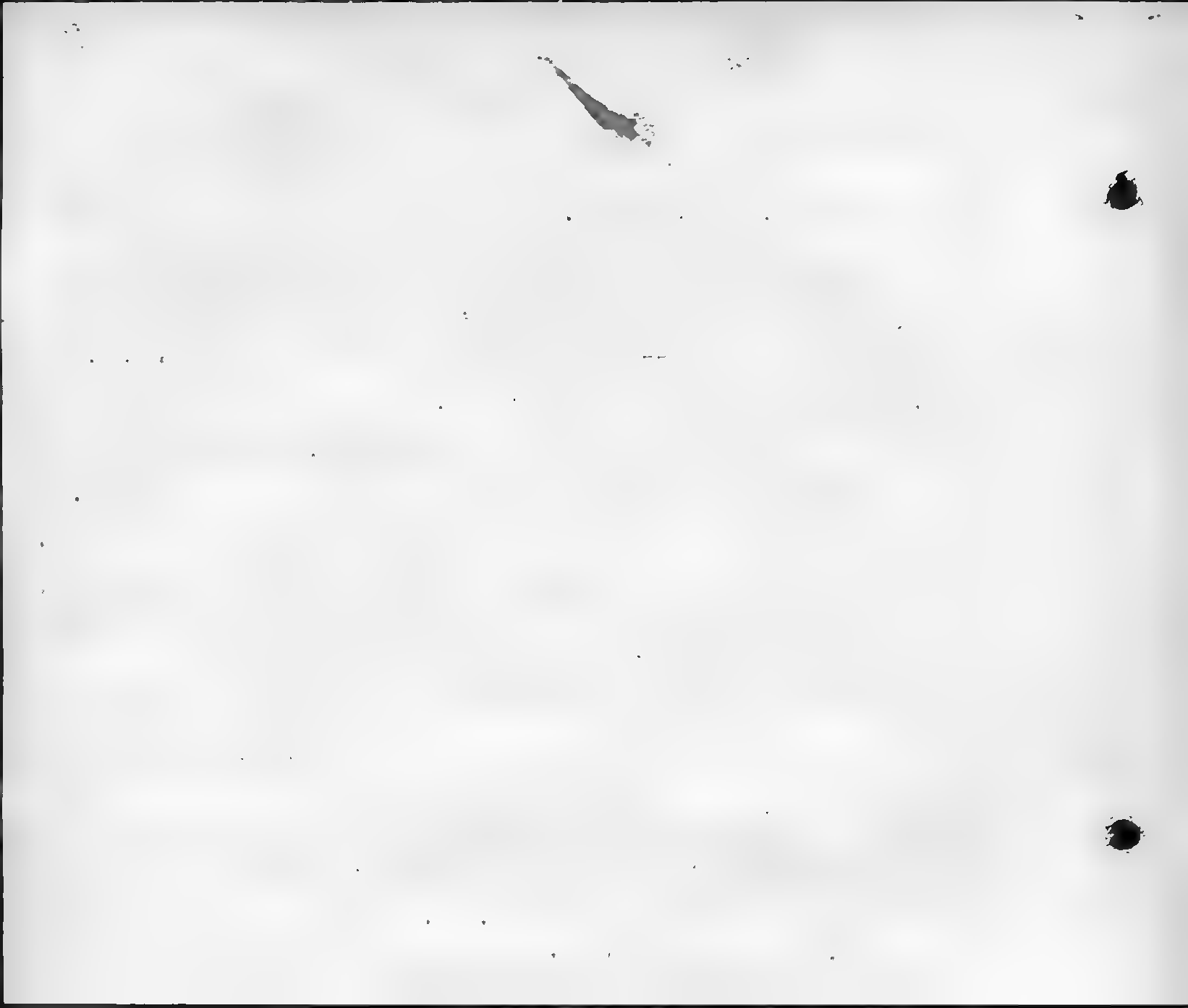
## CERTIFICATE OF DEATH

## 11477

Reg. Dist. No.

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institut. Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Prince Georges</u>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                      | c. LENGTH OF STAY IN 1b<br><u>99 days</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda 14, Md.</u>  |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Helen</u> Middle <u>Irene</u> Last <u>Duley</u>   |                                      | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>17</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 16, 1899</u>                                 |
| 9. AGE (In years last birthday)<br><u>59</u> yrs   |                                      | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |                                      | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>  |   |
| 13. FATHER'S NAME<br><u>John W. Edelen</u>   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Mary A. Brady</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) <u>no</u><br>(If yes, give war or dates of service)   |                                      | 16. SOCIAL SECURITY NO.<br><u>Unascertainable</u>   |   |
| 17. INFORMANT<br><u>The Medical Record</u>   |                                      | Address<br><u>The Clinical Center, Bethesda 14, Maryland</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                      |   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anemia and Malnutrition</u>   |                                      |   |   |
| 19a. 9 DUE TO  |                                      |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |                                      |   |   |
| (b) <u>Osteogenic Sarcoma</u>  |                                      |   |   |
| DUE TO   |                                      |   |   |
| (c) <u>Osteitis deformans</u>  |                                      |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo.</u>   |                                      |   |   |
| <u>2-3 mos.</u>  |                                      |   |   |
| <u>14-15 yrs.</u>  |                                      |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                      |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>July 10, 1958</u> to <u>October 17, 1958</u> , that I last saw the deceased alive on <u>October 17, 1958</u> , and that death occurred at <u>3:00 A.</u> M, from the causes and on the date stated above. |                                      |   |   |
| ACTUAL SIGNATURE <u>Leo Lutwak</u>   |                                      | DATE SIGNED <u>10-17-58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Leo Lutwak, M. D.</u>   |                                      | ADDRESS (Street, city or town, state) <u>The Clinical Center</u><br><u>National Institutes of Health</u><br><u>Bethesda 14, Maryland</u>                    |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>10/20/58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cheltenham Meth. Cem.</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Cheltenham, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ritchie Bros. Upper Marlboro, Md.</u>   |                                      | 24. REC'D BY REGISTRAR<br>DATE <u>OCT 22 '58</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Leo S. Kline</u>  |                                      |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11505

## CERTIFICATE OF DEATH

Reg. Dist. No.

11478

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Chevy Chase</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |                                  | d. STREET ADDRESS <b>Street</b><br><b>4428 Stanford Court</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOLA</b> Middle <b>A</b> Last <b>DUNNING</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>20</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec 18, 1887</b><br><b>July 18, 1889</b> |
| 9. AGE (in years last birthday)<br><b>70</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>2</b> Hours <b></b> Min <b></b>  |   |
| 11. IF UNDER 24 HRS<br>Hours <b></b> Min <b></b>   |                                  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Abrom Charles Allison Hargett</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Clara A. Richter</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mr. Charles R. Hargett-Chevy Chase, Md.</b>  |                                  | Address <b>7104-46th St.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b><br>DUE TO <b>Essential Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b><br>(c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> |                                  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>10 years</b>   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Sept 1948</b> to <b>10/20 1958</b> , that I last saw the deceased alive on <b>10/20 1958</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE <b>James T. Burns</b>   |                                  | ADDRESS (Street, city or town, state) <b>915-19th St NW, Washington, D. C.</b>  |   |
| PHYSICIAN'S NAME (Type) <b>JAMES T. BURNS M.D.</b>   |                                  | DATE SIGNED <b>10/21/58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10/23/58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |                                  | ADDRESS<br><b>Bethesda, Maryland</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>OCT 22 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kins</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



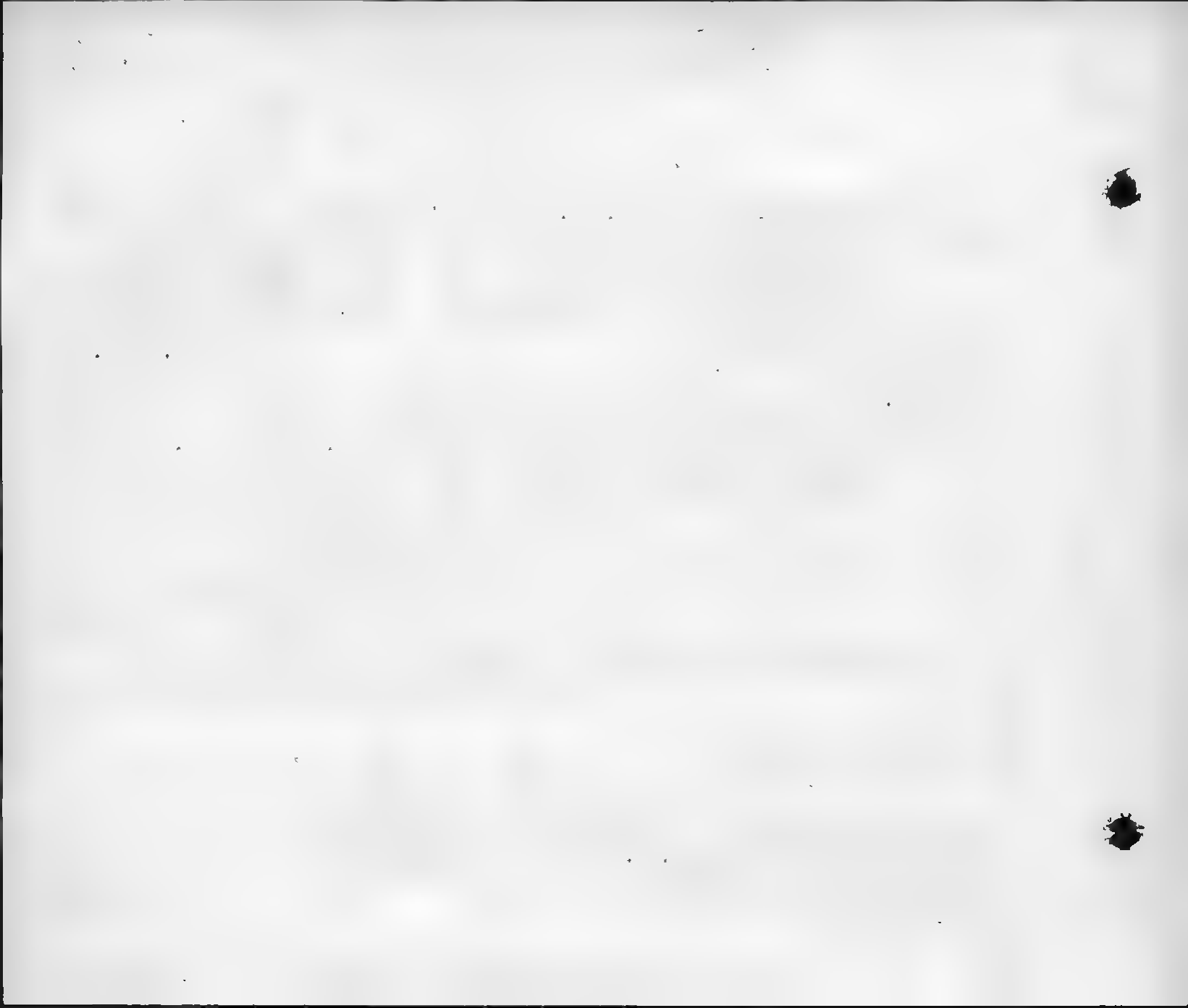
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11506 CERTIFICATE OF DEATH

Reg. Dist. No. **11479**

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ss on)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Hill</b> |   |
| c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |                                  | d. STREET ADDRESS<br><b>3802 Weltham Street</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Lucinda Kathryn Engle</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 23 1958</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>September 13, 1947</b> |
| 9. AGE (In years last birthday)<br><b>11 yrs</b>  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Norbert J. Engle</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alma Horacek</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>None</b>  |   |
| 17. INFORMANT The Medical Record Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |                                  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic Tracheobronchitis with massive tracheal</b><br><b>204.3</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hemorrhage; and cerebral edema and cerebellar herniation</b><br>(c) <b>Acute lymphocytic Leukemia</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>13 months</b> |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>October 20, 1958</b> to <b>October 23, 1958</b> , that I last saw the deceased alive on <b>October 23, 1958</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Nathan S. Taylor</b> M.D.  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>The Clinical Center 10-24-58</b><br><b>National Institutes of Health Bethesda 14, Maryland</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Nathan S. Taylor, M. D.</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>25 Oct 1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>RINALDI FUNERAL HOME 816 H ST NE WASH D.C.</b>   |                                  | 22d. LOCATION (City, town or county) (State)<br><b>YANKTON South DAKOTA</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>RINALDI</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 28 '58</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Cathy S. Kraus</b>   |                                  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



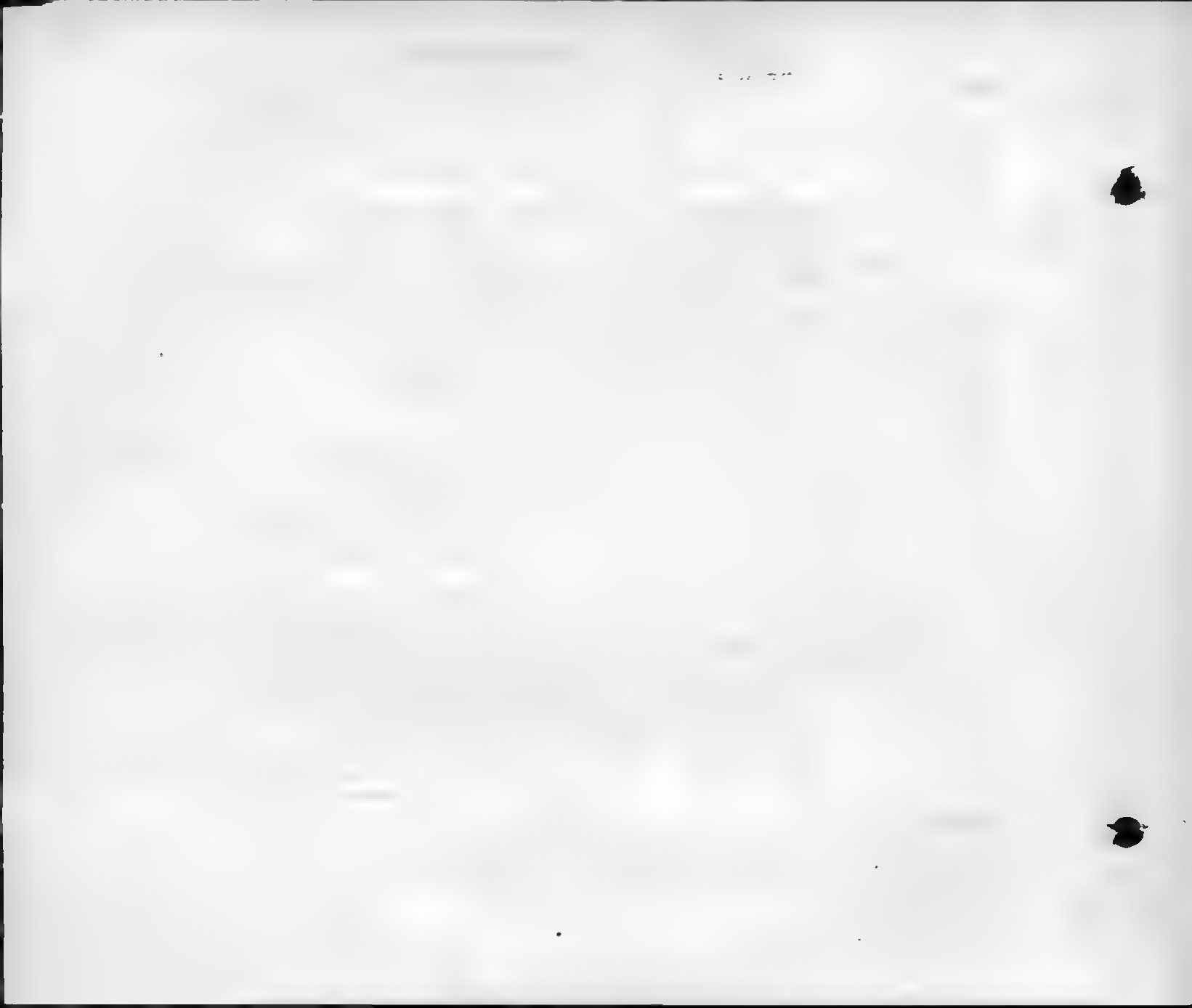
11507 CERTIFICATE OF DEATH

11480

Reg. Dist. No. 215

|  |                                  |   |                                    |   |                           |   |                          |
|--|----------------------------------|---|------------------------------------|---|---------------------------|---|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Washington, D.C.</b> b. COUNTY |                           |   |                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>19 days</b>   |                           |   |                          |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital, NNM</b>   |                                  |   |                                    | d. STREET ADDRESS<br><b>2511 Palmer Place</b>   |                           |   |                          |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Agnes</b> Last <b>FAGAN</b>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>19</b> Year <b>19 58</b>  |                           |   |                          |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-14-88</b> | 9. AGE (In years last birthday)<br><b>70</b> yrs  | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS<br>Days   | IF UNDER 24 HRS<br>Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Mass.</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                          |
| 13. FATHER'S NAME<br><b>James (N) FLANAGAN</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Sara (N) WARD</b>  |                           |   |                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |                                    | 17. INFORMANT<br><b>(H) Patrick F. FAGAN, same as #2 above</b>  |                           |   |                          |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>443X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>40X</b><br>(b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO<br>(c) <b>Arterio sclerosis</b> |                                  |   |                                    |   |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>several years</b><br><b>11</b>                  |                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>a) Diabetes Mellitus &amp; b) Gastrointestinal bleeding</b>  |                                  |   |                                    |   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>2</b>   |                                    | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |                           | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |                          |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town)   |                                    | (County)  |                           | (State)   |                          |
| 21. I certify that I attended the deceased from <b>September 30 19 58</b> , to <b>October 19 19 58</b> , that I last saw the deceased alive on <b>October 19 19 58</b> , and that death occurred at <b>3:40P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNM</b> DATE SIGNED <b>10-20-58</b>                   |                                  |   |                                    |   |                           |   |                          |
| ACTUAL SIGNATURE <b>Thomas R. Ulshaffer</b> M.D.   |                                  |   |                                    | PHYSICIAN'S NAME (Type) <b>T. R. ULSHAFFER, CDR, MC, USN</b>  |                           |   |                          |
| 22a. BURIAL, CREMATON, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-22-58</b>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |                           | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>                               |                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b> ADDRESS <b>Simmons Brothers Funeral Home, S.E. Wash.D.C.</b>  |                                  |   |                                    | 24a. REC'D BY REGISTRAR<br><b>OCT 21 58</b>   |                           | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hunt</b>  |                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11481

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

11508

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>                    |  |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>16 years</b>   |                                  | d. STREET ADDRESS<br><b>9408 Columbia Blvd.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9408 Columbia Blvd.</b>   |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>William H. Fidler</b>  |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>21</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 13, 1883</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired (Fireman) D. C.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>Frank Fidler</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Barnett</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-26-4542</b>   |  |
| 17. INFORMANT<br><b>Mrs. Ida K. Fidler</b>   |                                  | Address<br><b>9408 Columbia Blvd. SS. Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b> |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>               |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Frank J. Broschart</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                  | DATE SIGNED<br><b>10-21-58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>10/24/58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROCK CREEK CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond A. Baska</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 24 '58</b>  |  |
| ADDRESS<br><b>Silver Spring, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If no deputy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8/11/54 10-17-54 et

## CERTIFICATE OF DEATH

11482

Reg. Dist. No.

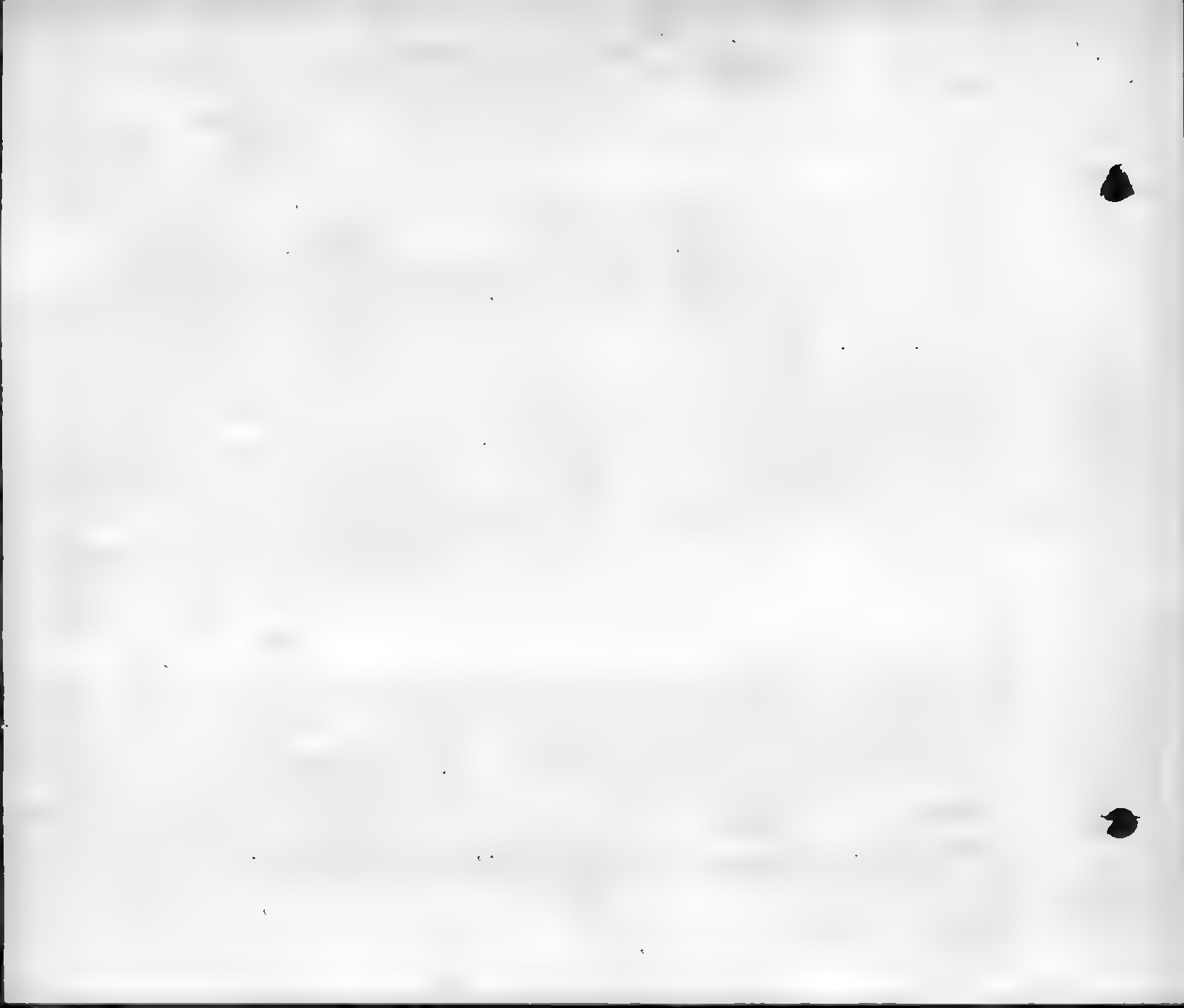
11509

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Suburban Hospital</b>   |  |  |  | d. STREET ADDRESS <b>102 University Ave.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>ROWLAND</b> First <b>B.</b> Middle <b>FIFER</b> Last  |  |  |  | 4. DATE OF DEATH <b>Oct. 6, 1958</b> Month <b>Oct.</b> Day <b>6</b> Year <b>19</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1893</b> <b>Apr. 14, 1884</b>  |  |
| 9. AGE (In years last birthday) <b>78</b> <b>69</b> yrs.   |  | IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b> |  | IF UNDER 24 HRS. Hours <b></b> Min. <b></b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Emp.</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>George Fifer</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Burnett</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <b>216-07-3702B</b>  |  |  |  |
|  |  |  |  | 17. INFORMANT <b>Ida L. Fifer-Item # 2</b> Address <b></b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular hemorrhage</b>  |  |  |  |  |  |  |  |
| X DUE TO <b>Hypertensive Cardiovascular Disease</b>  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b>   |  |  |  |  |  |  |  |
| DUE TO (c) <b></b>   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b> <b>several years</b>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>a. m.</b> p. m. <b></b>   |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>                 |  |
|  |  |  |  | 20f. (City or town) <b></b> (County) <b></b> (State) <b></b>   |  |  |  |
| 21. I certify that I attended the deceased from <b>12/25/51</b> , 19 <b></b> , to <b>10/6/58</b> , 19 <b></b> , that I last saw the deceased alive on <b>10/6/58</b> , 19 <b></b> , and that death occurred at <b>4:35 A. M.</b> from the causes and on the date stated above. |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>I. L. Marks</b>  |  |  |  | ADDRESS (Street, city or town, state) <b>6306 Wisconsin Ave. N.W., Wash. D.C.</b> DATE SIGNED <b>10/6/58</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>I. L. Marks</b>   |  |  |  | 6306 Wis. Ave., Chevy Chase, Md. <b>10/6/58</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>10/8/58</b>               |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b> ADDRESS <b></b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>OCT 8 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Carl S. K...</b>   |  |

TO SPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
8M 2/57

FOR STATE  
HEALTH DEPT.

Item 21 Film 236 11-20-58  
Item 18-21 Film 236 11-20-58  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No. 11483

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Montg.</u> <u>Pr. Geo.</u>     |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |  | c LENGTH OF STAY IN TB<br><u>16 hrs</u>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington San. &amp; Hosp.</u>   |  | e STREET ADDRESS<br><u>1017 Univ. Blvd., East</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Anne</u> Middle <u>H</u> Last <u>Fine</u>  |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>18</u> Year <u>1958</u>  |   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/5/13</u> <u>10/3-13</u>                                   |
| 9. AGE (In years last birthday)<br><u>45</u> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bookkeeper</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Giant Food</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Poland</u> <u>NEW YORK</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Simon Herson</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Esther Siegal</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO<br><u>Hosp. Records</u>  |   |
| 17. INFORMANT<br><u>Hosp. Records</u>   |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pending</u> <u>Barbiturate poisoning</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(c), stating the underlying cause last. (c) <u>  </u>  |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>10 hrs</u>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Reported to have taken a number of nembutal caps.</u>      |   |
| 20c. TIME OF INJURY<br>Hour <u>11</u> <u>pm</u> Month, Day, Year <u>10-16-58</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>home</u>   | 20f. (City or town) (County) (State)<br><u>Silver Spring</u> <u>P.G.</u> <u>Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
|   |  | DATE SIGNED <u>10/17/58</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10/19-1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Nat'l Memorial Park</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Falls Church</u> <u>Va</u>      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Goldberg Funeral Home Wash Dc</u>  |  | 24. REC'D BY REGISTRAR<br>DATE <u>OCT 20 58</u>   |   |
| ADDRESS<br><u>Goldberg Funeral Home Wash Dc</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>C. W. S. K. H. S.</u>  |   |



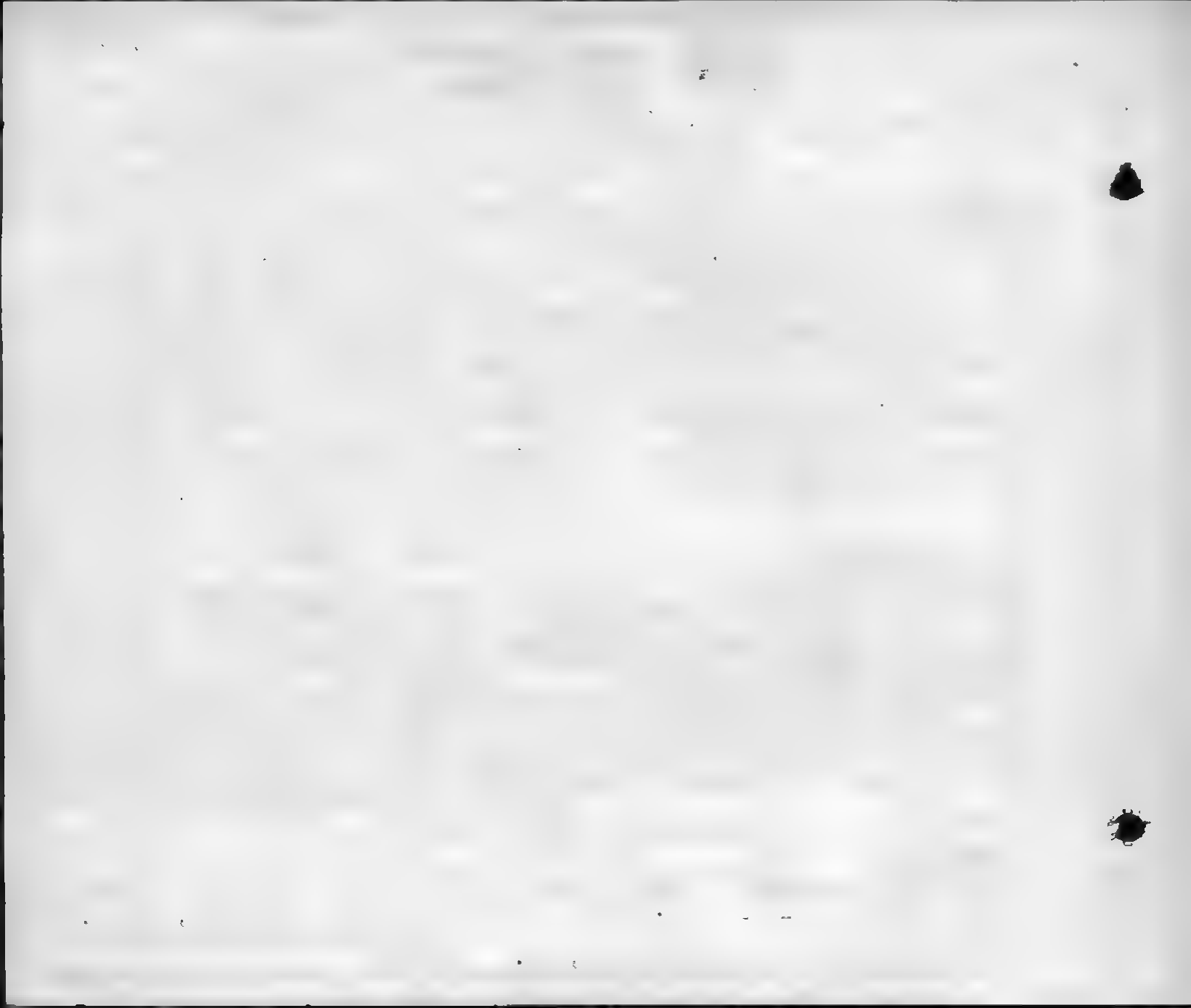
## 11510 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b><br>c. LENGTH OF STAY IN 1b<br><b>13 yrs.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>3805 Williams Lane</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Chevy Chase</b><br>d. STREET ADDRESS<br><b>3805 Williams Lane</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>MOLLIE</b> First <b>I.</b> Middle <b>GALLATIN</b> Last  |                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>24,</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>May 26, 1866</b>  |
| 9. AGE (In years last birthday)<br><b>92</b>  |                                      | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>28</b>  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                 |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      | 13. FATHER'S NAME<br><b>George H. Imboden</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Maria Petry</b>  |                                      | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                      | 17. INFORMANT<br><b>Eliz. G. Snoke - Item # 2</b><br>Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure &amp; edema</b><br><b>OX</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition &amp; Marasmus</b><br>DUE TO<br>(c) <b>Surgical emphysema &amp; pneumonia</b>  |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>3 months</b><br><b>?</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b></b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |
| 20f. (City or town)<br><b>Lebanon</b>   |                                      | (County) <b>Penna.</b> (State)   |  |
| 21. I certify that I attended the deceased from <b>March 24, 1949</b> to <b>Oct 24, 1958</b> , that I last saw the deceased alive on <b>23 Oct 1958</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5024 BETHEL AVE</b> DATE SIGNED <b>24 Oct 58</b><br>ACTUAL SIGNATURE <b>Herbert M. ...</b> M.D. <b>5024 BETHEL AVE</b><br>PHYSICIAN'S NAME (Type) <b>HERBERT M. ...</b> |                                      |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-transit</b>  | 22b. DATE THEREOF<br><b>10-26-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Annville Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Lebanon County, Penna.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 27 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>i. l. S. ...</b>   |                                      |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11511

## CERTIFICATE OF DEATH

11485

Reg. Dist. No.

|  |                               |  |  |  |  |
|--|-------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>13 days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>   |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u><br>d. STREET ADDRESS <u>16-Q Ridge Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>Glover</u>   |                               |  | 4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1958</u>   |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 10, 1953</u>  |  | 9. AGE (In years last birthday) <u>4</u> yrs       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>     |  |
| 13. FATHER'S NAME <u>Melvyn R. Glover</u>  |                               |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Josephine S. Bofamy</u>  |                               |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |  |
| 16. SOCIAL SECURITY NO <u>None</u>   |                               |  | 17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u><br><u>204.3</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lymphocytic Leukemia</u> DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u><br><u>18 mos</u> |                               |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                               |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |                               |  |  |  |  |
| 21. I certify that I attended the deceased from <u>October 6, 1958</u> to <u>October 19, 1958</u> that I lost saw the deceased alive on <u>October 19, 1958</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above   |                               |  |  |  |  |
| ACTUAL SIGNATURE <u>Arthur L. Teplitzky</u> M.D.   |                               |  | ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>10/20/58</u>   |  |  |
| PHYSICIAN'S NAME (Type) <u>Arthur L. Teplitzky, M.D.</u>   |                               |  | National Institutes of Health<br><u>Bethesda 14, Maryland</u>  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>10-22-58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>                   |  |
| 22d. LOCATION (City, town, or county) <u>Bladensburg, Md.</u>  |                               | (State) _____  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>Washington D.C.</u>  |                               |  | 24a. REC'D BY REGISTRAR <u>Oct 22 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>William S. Krand</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11512 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>114 E. Quincy Street</b>  |                                      | d. STREET ADDRESS<br><b>114 E. Quincy Street</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAY</b> Middle <b>ANN</b> Last <b>GREEN</b>  |                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>7,</b> Year <b>19 58</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/26/1881</b>  |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |                                      | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>11</b> Hours <b></b> Min. <b></b>  | IF UNDER 24 HRS<br>Hours <b></b> Min. <b></b>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>France</b>                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |   |   |
| 13. FATHER'S NAME<br><b>Carl Krus</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>? Borchard</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                      | 16. SOCIAL SECURITY NO<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Oliver G. Green-</b>   |                                      | Address <b>3378 Stephenson Pl. N.W.</b><br>Son  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute Severe</b><br><b>4 a.m.</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Advanced coronary sclerosis</b><br>(c) <b>Essential Hypertension with arterioscl.</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 minutes</b><br><b>5 yrs +</b><br><b>5 yrs +</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY<br>Month <b></b> Day <b>19</b> Year <b>19</b><br>Hour <b></b> a. m. <b></b> p. m. <b></b>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1948</b> to <b>Oct 7, 1958</b> , that I last saw the deceased alive on <b>Oct 2, 1958</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.   |                                      |   |   |
| ADDRESS (Street, city or town, state)<br><b>3921 Ingomar St. Wash 15 D.C.</b>  |                                      | DATE SIGNED<br><b>Oct 7/1958</b>  |   |
| ACTUAL SIGNATURE<br><b>Stewart Clapp</b>   |                                      | M.D. <b>3921 Ingomar St. Wash 15 D.C.</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Stewart Clapp</b>  |                                      |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10/10/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Silver Spring, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |                                      | ADDRESS<br><b>Bethesda, Maryland</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>  |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

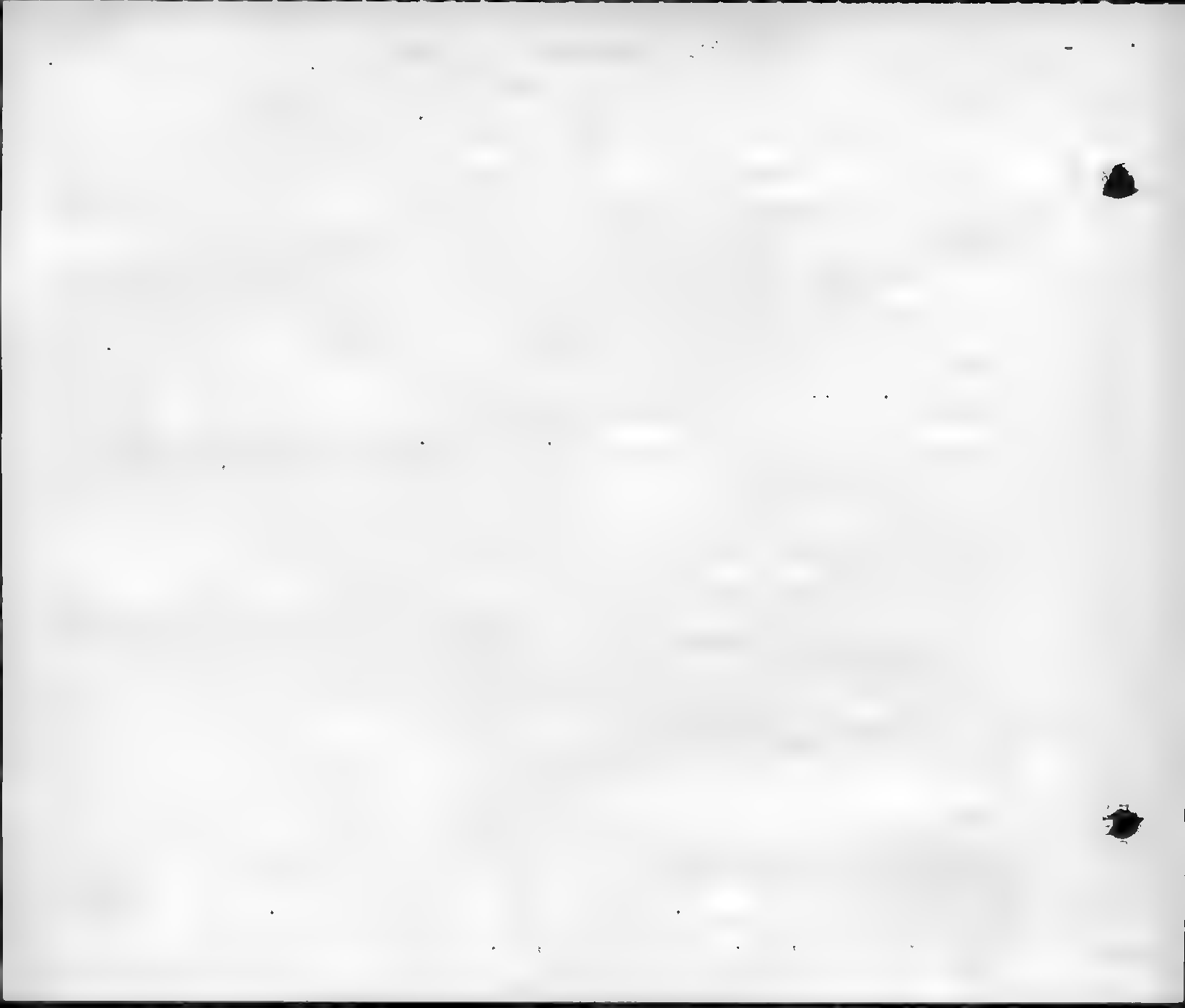
## 11513

## CERTIFICATE OF DEATH

## 11487

Reg. Dist. No.

|   |                                  |   |   |   |  |  |  |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>Mass.</u> b. COUNTY |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Sandy Springs</u>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Waverly</u>                      |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Brooke's Home Foundation</u>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Margaret</u> Middle <u>Sarah</u> Last <u>Greene</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>14</u> Year <u>1958</u> |   |  |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2/28/80</u>                                  |   | 9. AGE (In years last birthday)<br><u>78</u> yrs.            | IF UNDER 1 YEAR<br>Months Days Hours Min   | IF UNDER 24 HRS.                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>                |   | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>      |
| 13. FATHER'S NAME<br><u>Olin D. Greene</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Berna Bee</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |   | 17. INFORMANT<br>Address<br><u>Mr. Raymond M. Greene, 934 Preston Drive</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br><u>434.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis due to Cerebral Vascular Accident</u> |                                  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Hours</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                            |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>March</u> , 1954, to <u>Oct 13</u> , 1958, that I last saw the deceased alive on <u>Oct 13</u> , 1958, and that death occurred at <u>9:25A</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>John Lawrence Avery, M.D. 10110 Georgia Ave. 10/14/58</u>   |                                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <u>John Lawrence Avery</u>   |                                  |   |   | PHYSICIAN'S NAME (Type) <u>John Lawrence Avery, MD Silver Spring, Md</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>CREMATION</u>   |                                  | 22b. DATE THEREOF<br><u>10/15/58</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>FT. LINCOLN CREMATORY</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>PRINCE GEO. COUNTY, MARYLAND</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond A. Ziska</u>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 16 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                                 |  |



CERTIFICATE OF DEATH

11488

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8802 Glenville Road</u>  |  | d. STREET ADDRESS <u>18802 Glenville Rd.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>S</u> Last <u>Guy</u>  |  | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1958</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan- 1892</u>  |
| 9. AGE (In years last birthday) <u>66</u> yrs.   |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>John W. Svann</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Annie Kaiser</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>Paul Guy</u>  |  | Address <u>8802-Glenville Rd. Takoma Park</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u><br>DUE TO (c) <u>Hypertensive vascular disease</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u><br><u>15 hrs.</u><br><u>15 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>Oct. 8</u> , 19 <u>58</u> , to <u>Oct. 9</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>Oct. 8</u> , 19 <u>58</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <u>Philip H. Varner, M.D.</u>   |  | DATE SIGNED <u>10-9-58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Philip H Varner</u>   |  | <u>Spring, Md.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-11-58</u>  | 22b. DATE THEREOF <u>10-11-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>   | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Dorothy Stanlow</u>  |  | 24a. REC'D BY REGISTRAR <u>Oct 10 '58</u>  |  |
| ADDRESS <u>831- 94 Ave NW</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>William S. Kaiser</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general direction TO FUNERAL DIRECTOR: Detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11514

CERTIFICATE OF DEATH

11489

Reg. Dist. No. 215

|   |                                  |  |                                     |
|---|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ss on)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>              |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>21 days</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |                                  | e. STREET ADDRESS<br><b>212 Hillmoor Drive</b>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Ellsworth</b> Last <b>HAAS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>6</b> Year <b>1958</b>   |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-17-37</b> |
| 9. AGE (In years last birthday) yrs<br><b>20</b>  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>John Ellsworth HAAS</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Thelma WHITE</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>6756 - 12/56</b>  |                                     |
| 17. INFORMANT<br><b>Father, John E. Haas, same as #2 above</b>  |                                  | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>Sept. 16, 1958</b> to <b>Oct. 6, 1958</b> , that I last saw the deceased alive on <b>Oct. 4, 1958</b> , and that death occurred at <b>12:35 AM</b> , from the causes and on the date stated above                                |                                  |  |                                     |
| ACTUAL SIGNATURE <b>A. Miale, Jr.</b>   |                                  | DATE SIGNED <b>10-6-58</b>   |                                     |
| PHYSICIAN'S NAME (Type) <b>A. MIALE, Jr., RT, MC USN</b>  |                                  | ADDRESS <b>U. S. Naval Hospital, NNMC</b>  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-8-58</b>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. E. Pumphrey, 8434 Georgia Ave., Silver Spring</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Oct 7 58</b>   |                                     |
| ADDRESS <b>Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><i>Wm. E. Pumphrey</i>   |                                     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



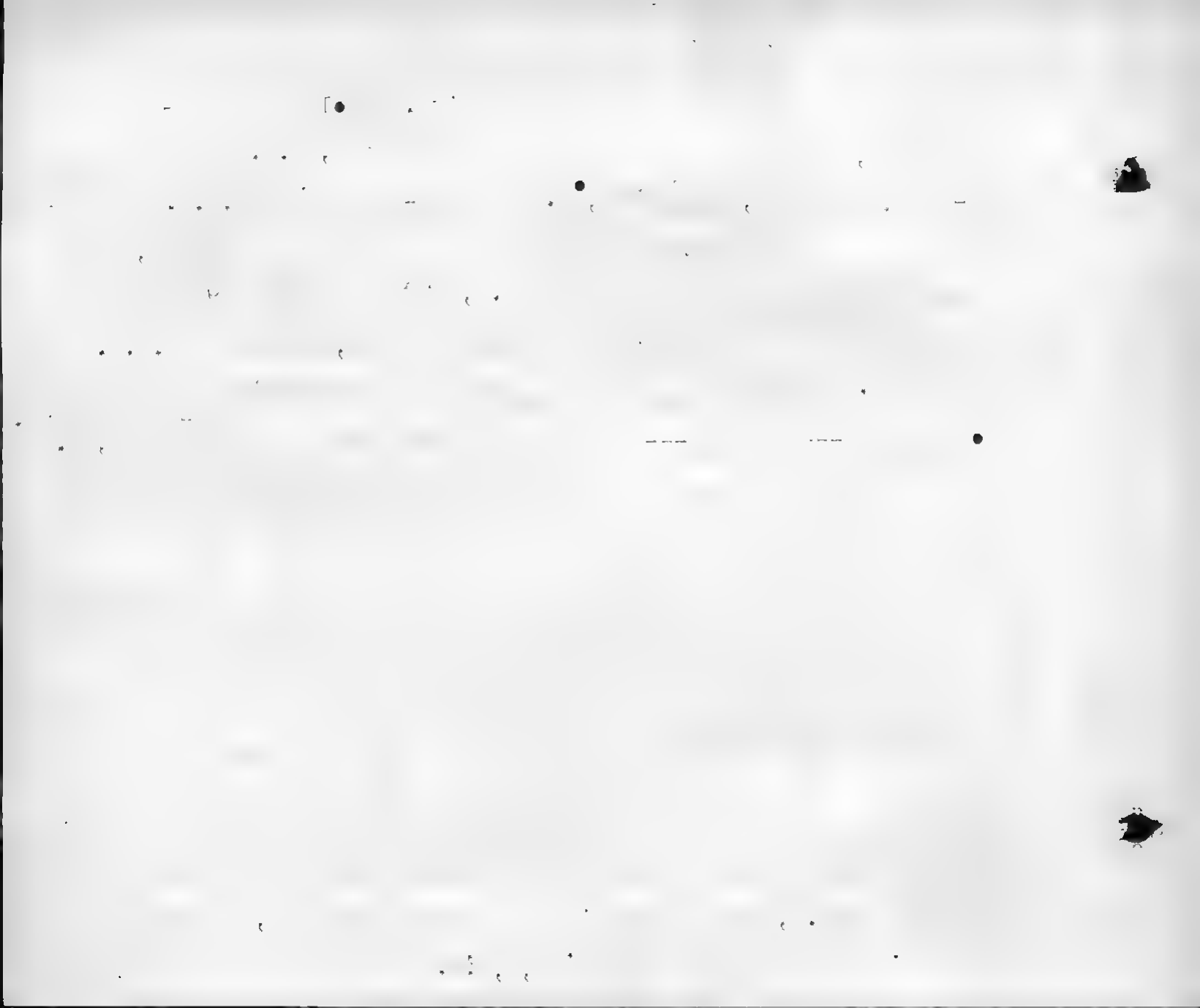
## 11515 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY COUNTY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>Dist. Of Col</b> b. COUNTY                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>KENSINGTON, MARYLAND</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>  |   |
| d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION<br><b>Kensington Gardens Home</b>  |                                  | d. STREET ADDRESS<br><b>3810-Southern Ave. S.E.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>FLORENCE MARIAN HAMMOND</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 29, 1958</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 1, 1878</b> |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min<br><b>9 29</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Secretary</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Smith Center, Kansas</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>James R. Hammond</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Abercrombie</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>---</b>   |   |
| 17. INFORMANT<br><b>Nursing Home Records</b>  |                                  | Address<br><b>3000-McComas Ave. Kensington, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)].<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast</b><br><b>170x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b> |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |   |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Sept. 1958</b> to <b>Oct. 29, 1958</b> , that I last saw the deceased alive on <b>10-25</b> , 1958, and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Jerome H. Epstein 2025-Eye St, NW, Wash DC</b><br>PHYSICIAN'S NAME (Type) <b>JEROME H. EPSTEIN 2025-EYE ST, NW 10/29/58</b>  |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                                  | 22b. DATE THEREOF<br><b>Nov. 1, 1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>MARTIN W. HYSOY COMPANY 1300 N. STREET</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 31 58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |                                  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11516

## CERTIFICATE OF DEATH

Reg. Dist. No. **11491**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Kensington</u> <u>Montgomery</u> <u>MARYLAND</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived; If institution, Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Kensington Garden Sanitarium</u>  |  |  |  | d. STREET ADDRESS<br><u>10205-Pierce Dr.</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Allison</u> Middle <u>A</u> Last <u>Hancock</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>13</u> Year <u>1958</u>   |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-24-90</u>                                     |  |
| 9. AGE (In years last birthday)<br><u>68</u> yrs   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |  | IF UNDER 24 HRS<br>Hours <u>  </u> Min <u>  </u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MAILER</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Newspaper</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Washington D.C.</u>    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Herman Hancock</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth ?</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>578-07-3530</u>  |  | 17. INFORMANT<br><u>Mrs Harry T. James-10205 Pierce Dr, Silver Sp</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u><br>DUE TO <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>  </u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |  |  |  | 20g. (County)  |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <u>May 5, 1958</u> 19 <u>  </u> to <u>Oct 13, 1958</u> 19 <u>  </u> that I last saw the deceased alive on <u>10/14/58</u> 19 <u>  </u> and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>  |  |  |  |  |  |  |  |
| ACTUAL REGISTRAR <u>SAM ALLEN M.D.</u> M.D.  |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Sam Allen, M.D.</u>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF                                  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| <u>Burial</u>  |  | <u>Oct 15-1958</u>                                 |  | <u>Cedar Hill</u>  |  | <u>Sanctuary Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. Wm Lee's Sons Wash Dc</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 14 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kraus</u>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11517 CERTIFICATE OF DEATH

11492

Reg. Dist. No.

|  |                               |  |  |  |                 |  |  |
|--|-------------------------------|--|--|--|-----------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u> |                 |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>   |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG, MD.</u>                            |                 |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>LESMORE SAN.</u>  |                               |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |                 |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>GUSSIE</u> Middle <u>-</u> Last <u>HARSANYI</u>   |                               |  |  | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1958</u>   |                 |  |  |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 10 - 1886</u> | 9. AGE (In years last birthday) <u>72</u> yrs.   | IF UNDER 1 YEAR | IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |                               |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>HUNGARY</u>   |                 | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>HYMAN BERKOWITZ</u>   |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>  |                 |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>578-36-8737-A</u>   |  | 17. INFORMANT <u>ALICE HOLDRON</u> Address <u>MD-3 GAITHERSBURG, MD.</u>   |                 |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS - DIFFUSE</u><br>X DUE TO <u>CANCER OF RECTUM</u><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3-4 YRS.</u><br>(c) <u>3-4 YRS.</u> |                               |  |  |  |                 | INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>  |                               |  |  |  |                 | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-</u>                                 |                 |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>  |                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>6/12, 1958</u> to <u>10/1, 1958</u> , that I last saw the deceased alive on <u>10/1, 1958</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.  |                               |  |  |  |                 |  |  |
| ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D.   |                               |  |  | ADDRESS (Street, city or town, state) <u>900-17ST., N.W. WASH., D.C.</u> DATE SIGNED <u>10/1/58</u>                                  |                 |  |  |
| PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>   |                               |  |  |  |                 |  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>CREMIAL</u>  |                               | 22b. DATE THEREOF <u>10/3/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>REC WASH Cem</u>   |                 | 22d. LOCATION (City town or county) (State) <u>HYATSVILLE, MD.</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Heather Hume</u> ADDRESS <u>4217-4th St NW</u>   |                               |  |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 3 '58</u>  |                 | 24b. REGISTRAR'S SIGNATURE <u>C. H. S. Frank</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11445

## CERTIFICATE OF DEATH

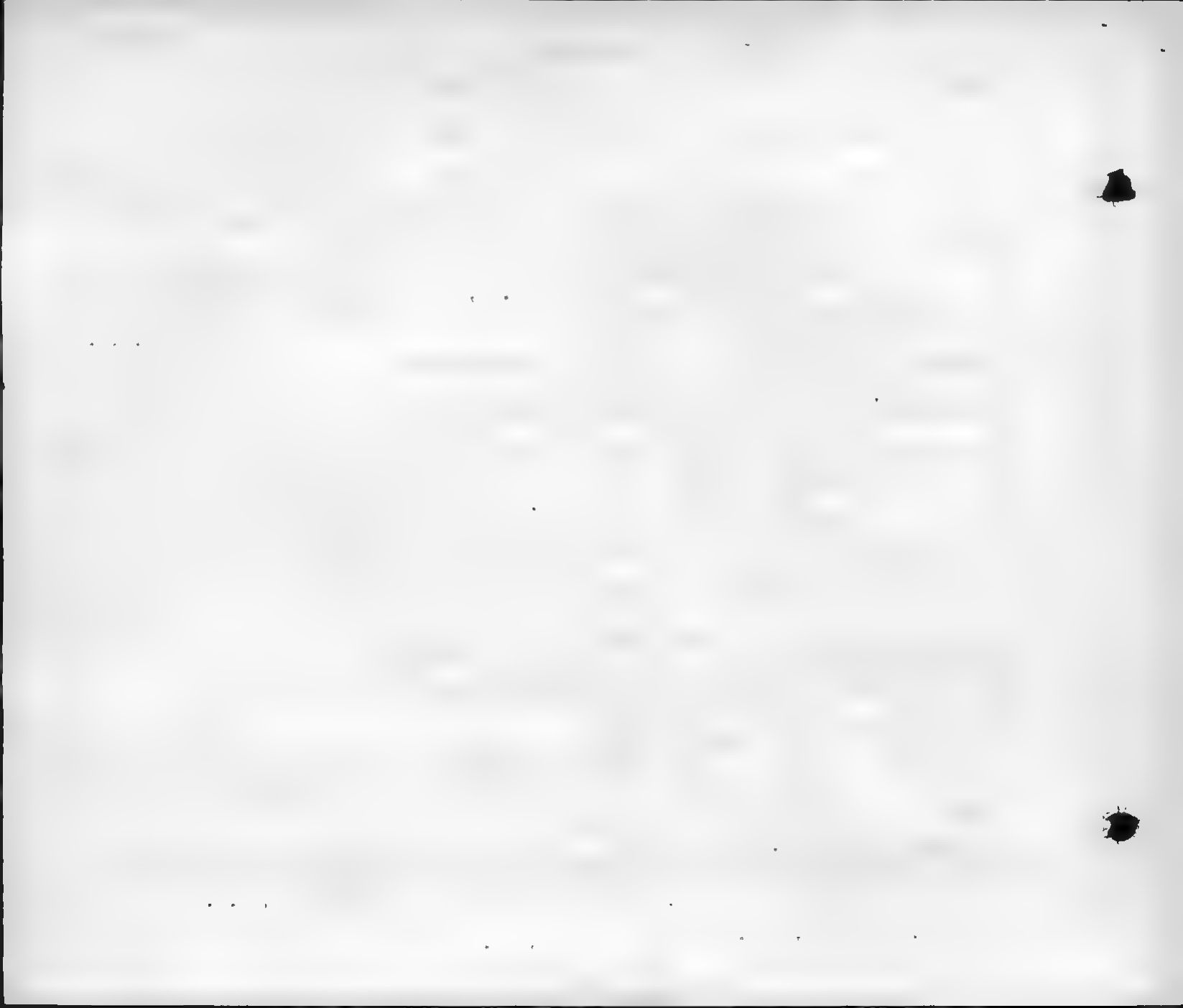
## 11493

Reg. Dist. No.

|   |  |   |  |   |   |   |   |
|---|--|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MONTGOMERY</u> b. COUNTY <u>PRINCE GEORGES</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>  |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>  |  |   |  | d. STREET ADDRESS <u>1400 1st St. S.E.</u>  |   |   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Blondale Theron Heath</u>  |  |   |  | 4. DATE OF DEATH Month Day Year <u>October 16 1958</u>  |   |   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 5, 1894</u>   | 9. AGE (In years last birthday) <u>64</u> yrs.  | 10. IF UNDER 1 YEAR: Months Days Hours Min.       |   | 11. IF UNDER 24 HRS: Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  | 13. FATHER'S NAME <u>Thomas M. Heath</u>  |   |   |   |
| 14. MOTHER'S MAIDEN NAME <u>ANNIE L. HART</u>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   |   |   |
| 16. SOCIAL SECURITY NO. <u>XXXXXXXXXXXX</u>   |  |   |  | 17. INFORMANT <u>ANNIE L. HART</u> Address <u>1400 1st St. S.E.</u>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>  |  |   |  |   |   |   |   |
| b. <u>416X</u> DUE TO <u>Rheumatic heart disease and</u>  |  |   |  |   |   |   |   |
| c. <u>Chronic congestive failure</u>  |  |   |  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spontaneous and massive bleeding</u>   |  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  | 20f. (City or town) <u>Prince Georges</u> (County) <u>Prince Georges</u> (State) <u>MD</u> |   |   |   |   |
| 21. I certify that I attended the deceased from <u>Jan. 5, 1894</u> to <u>Oct 16, 1958</u> , that I last saw the deceased alive on <u>Oct 16, 1958</u> , and that death occurred at <u>9:50</u> M., from the causes and on the date stated above. |  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <u>Bernard A. FitzGerald</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>217 University Heights S.E. 16, D.C.</u>   |   |   |   |
| PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>  |  |   |  | DATE SIGNED <u>10-17-58</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>10/20/58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>   | 22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u> (State) <u>D.C.</u>          |   |   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>  |  |   |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 20 1958</u>   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u> |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11446

## CERTIFICATE OF DEATH

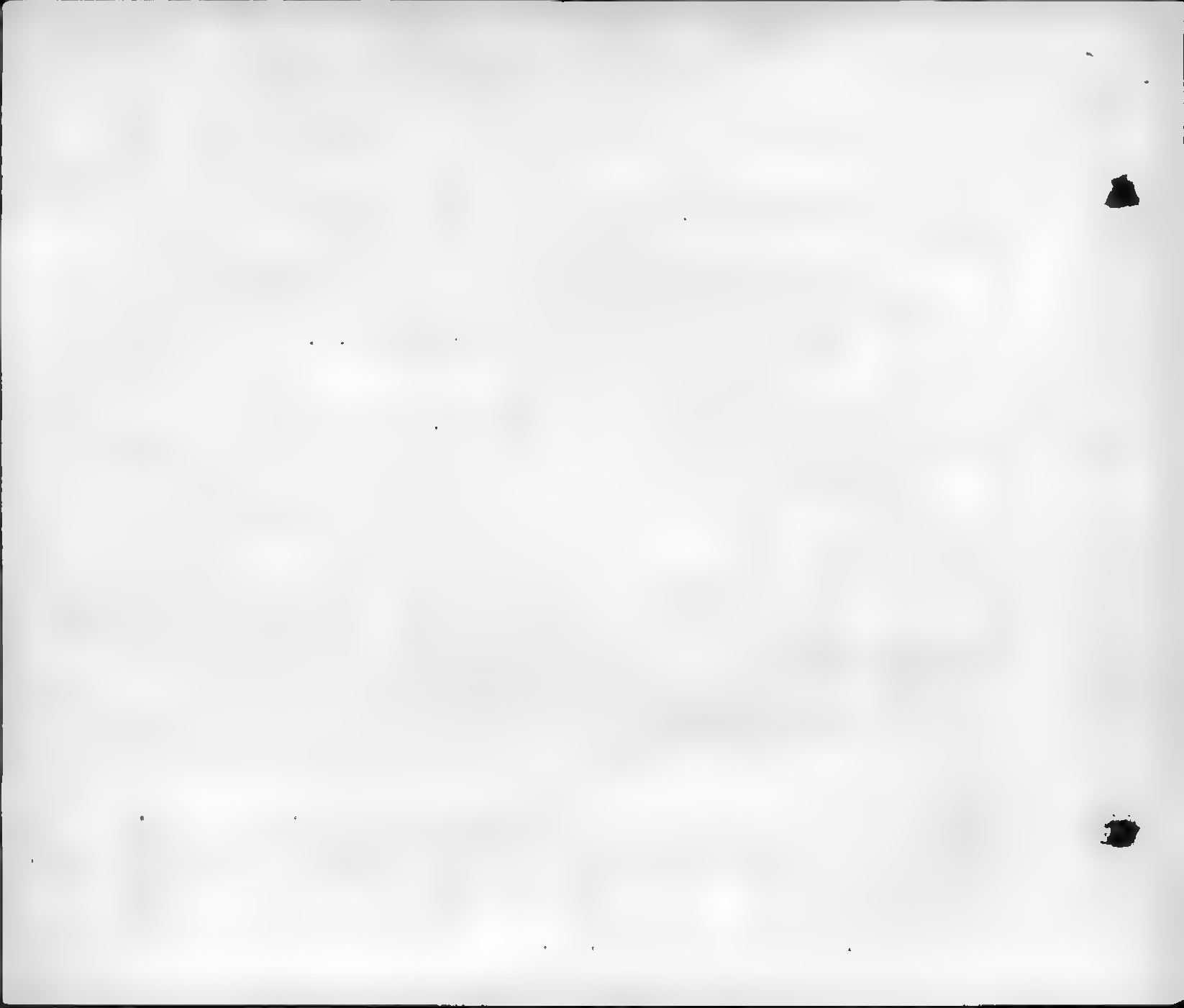
11494

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington Sanitarium &amp; Hospital</u>   |                                  | d. STREET ADDRESS<br><u>10 Jefferson Ave</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>DANIEL</u> First <u>EDWIN</u> Middle <u>HEWITT</u> Last  |                                  | 4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-14-58</u>   |
| 9. AGE (In years lost birthday) yrs. <u>16</u>  |                                  | IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
|   |                                  | <u>Washington, D. C.</u>   |   |
| 11. BIRTHPLACE (State or foreign country)   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| <u>Washington, D. C.</u>  |                                  | <u>U.S.</u>  |   |
| 13. FATHER'S NAME<br><u>Albert Timmons Hewitt</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>ELEANOR ELAINE Cullver</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO. <u>—</u>   |   |
| 17. INFORMANT<br><u>Albert T. Hewitt-Item # 2</u> Address <u>CHART - PARENTS</u>  |                                  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonitis</u><br><u>759.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aspiration</u><br>(c) <u>Congenital laryngeal stenosis</u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myelo-meningocele - lumbar</u>   |                                  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>10-14-</u> , <u>1958</u> , to <u>10-30-</u> , <u>1958</u> , that I last saw the deceased alive on <u>10-30-58</u> , and that death occurred at <u>11:35</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                          |                                  |  |   |
| ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D. <u>927 Pershing Dr. Silver Sp.</u>  |                                  | <u>10/30/58</u>  |   |
| PHYSICIAN'S NAME (Type) <u>DR. WINSTON E. Cochran 927 Pershing Dr. Silver Spring, Md.</u>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)                                       |
| <u>Burial</u>   | <u>11/1/58</u>                   | <u>National Memorial Park</u>  | <u>Falls Church, Virginia</u>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-Bethesda, Md.</u>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 5 58</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Ernest E. Harris</u>                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11518 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Florida</u> b. COUNTY <u>Leonard</u>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>67 Division Ave.</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5905 Wilmette</u>   |  | d. STREET ADDRESS <u>33 Division Ave.</u>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank G. Hinckley</u>  |  | 4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1958</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/18/78</u>                                   |
| 9. AGE (In years last birthday) <u>80</u> yrs.  |  | IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - lawyer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Lawyer</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Marshall (?) Hinckley</u>  |  | 14. MOTHER'S MARDEN NAME <u>Crocker (Crocker)</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>-</u>  |   |
| 17. INFORMANT <u>Daughter - Mrs. Tammmer</u>  |  | Address <u>5905 Wilmette</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>associated with Left sided congestive heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>and Respiratory infection</u><br>(b) <u>and</u> (c) <u>Respiratory infection</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>and heart failure</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Hour a. m. <u>-</u> p. m. <u>-</u> Month <u>-</u> Day <u>19</u> Year <u>-</u>   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                              |
| 21. I certify that I attended the deceased from <u>Oct 20, 1958</u> to <u>Oct 22, 1958</u> , that I last saw the deceased alive on <u>Oct 21, 1958</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above   |  |   |   |
| ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>8601 old George town Road Bethesda Md.</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>   |  | DATE SIGNED <u>Oct 21, 1958</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>  | 22b. DATE THEREOF <u>10/22/58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>  | 22d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's Sons</u>  |  | ADDRESS <u>Washington, D.C.</u>   |   |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 23 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

\* Funeral held in bed AM of Oct 24, 1958. Pronounced dead at 9 AM - 1958 - by warm but not breathing.



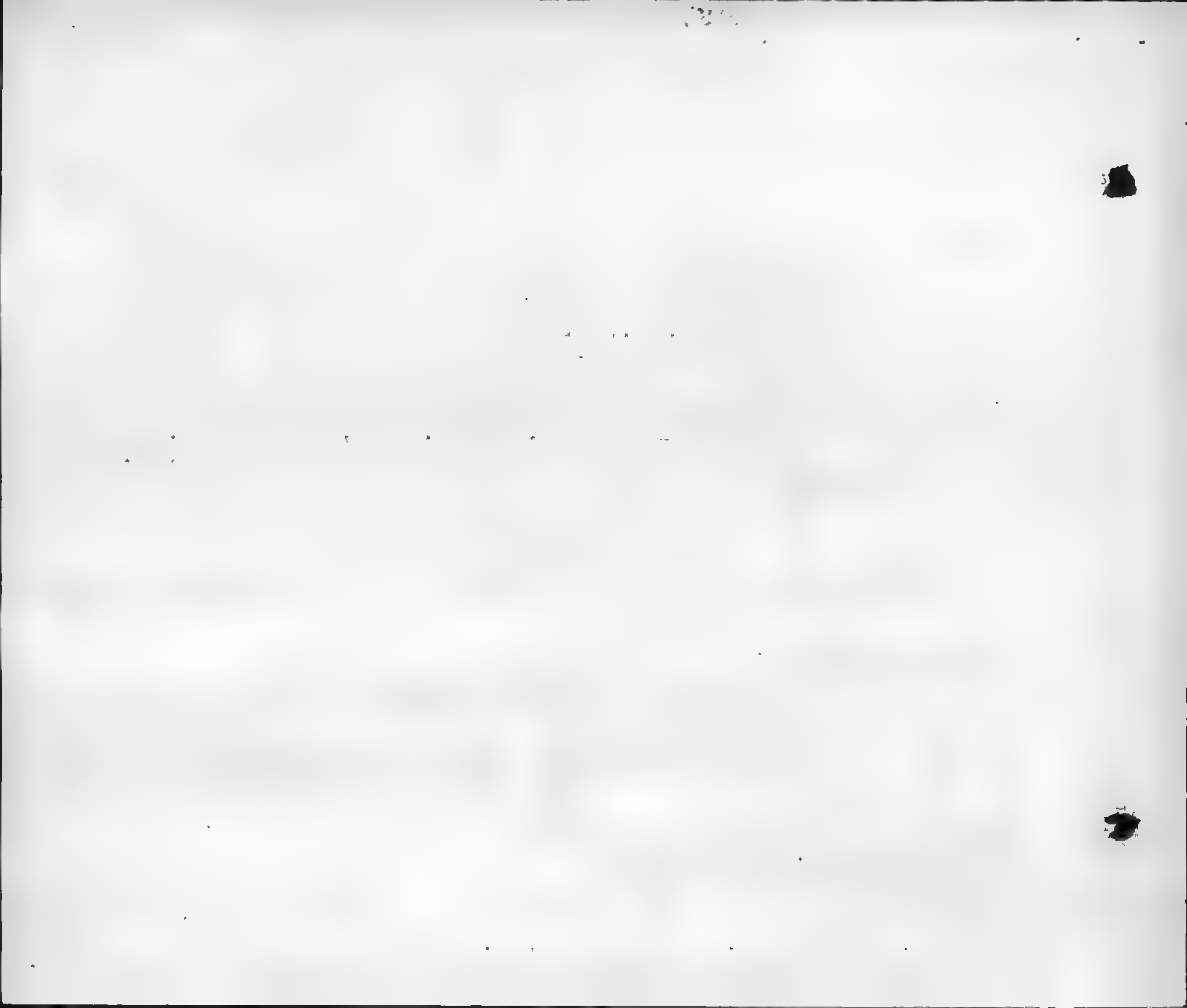
11519 CERTIFICATE OF DEATH

11496

Reg. Dist. No.

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FAIRLAND</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>FAIRLAND NURSING HOME</u>  |                           | d. STREET ADDRESS<br><u>616 Eldred Dr</u>  |                                      |
| 3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>F</u> Last <u>Hobbs</u>  |                           | 4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1958</u>  |                                      |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Jan 8 - 1876</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs.  |                           | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Justice of the Peace</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Mont. Co., Md.</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |                                      |
| 13. FATHER'S NAME<br><u>Marian Franklin Hobbs</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>Martha Johnson</u>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>217-32-0492</u>   |                                      |
| 17. INFORMANT<br><u>Mrs. Alice M. Hobbs, 616 Eldred Dr., Silver Spring, Md.</u>   |                           | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis with cerebral thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u><br>DUE TO<br>(c) <u>Unknown</u> |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |                           | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <u>1949</u> to <u>Oct 12</u> , 1958, that I last saw the deceased alive on <u>October 8</u> , 1958, and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D. <u>8257 Georgia Ave Silver Spring, Md. Oct 12 1958</u><br>PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u> |                           |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                           | 22b. DATE THEREOF<br><u>10/15/58</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>COLESVILLE CEMETERY</u>  |                           | 22d. LOCATION (City, town, or county) (State)<br><u>MONTGOMERY COUNTY, MARYLAND</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>WALTER E. PUMPUREY, INC.</u><br><u>Raymond W. Ziska</u>  |                           | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 15 58</u>   |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Traud</u>   |                           |  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11497

Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>6 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>Pennsylvania</b><br>b. COUNTY<br><b>Columbia</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Columbia</b><br>d. STREET ADDRESS<br><b>555 Maple Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Beth Louise Hollingsworth</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 19, 1958</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>January 20, 1950</b> |
| 9. AGE (In years last birthday)<br><b>8 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Lee J. Hollingsworth</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Janet F. Yentzer</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>None</b>  |   |
| 17. INFORMANT<br><b>The Medical Record</b>   |                                  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>acute Lymphoblastic leukemia</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>None</b><br><b>1 yr</b>                                      |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br>Month, Day, Year<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>October 13, 1958</b> to <b>October 19, 1958</b> , that I last saw the deceased alive on <b>October 19, 1958</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br>DATE SIGNED<br><b>10/20/58</b><br>NATIONAL INSTITUTES OF HEALTH<br>Bethesda 14, Maryland |                                  |   |   |
| ACTUAL SIGNATURE<br><b>G. Richard Lee, M. D.</b>   |                                  | PHYSICIAN'S NAME (Type)<br><b>G. Richard Lee, M. D.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>OCT. 23 1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>CONCORDIA LUTHERAN</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>CHESTNUT HILL LANC. PENN.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles W. Frost</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 22 1958</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |   |   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

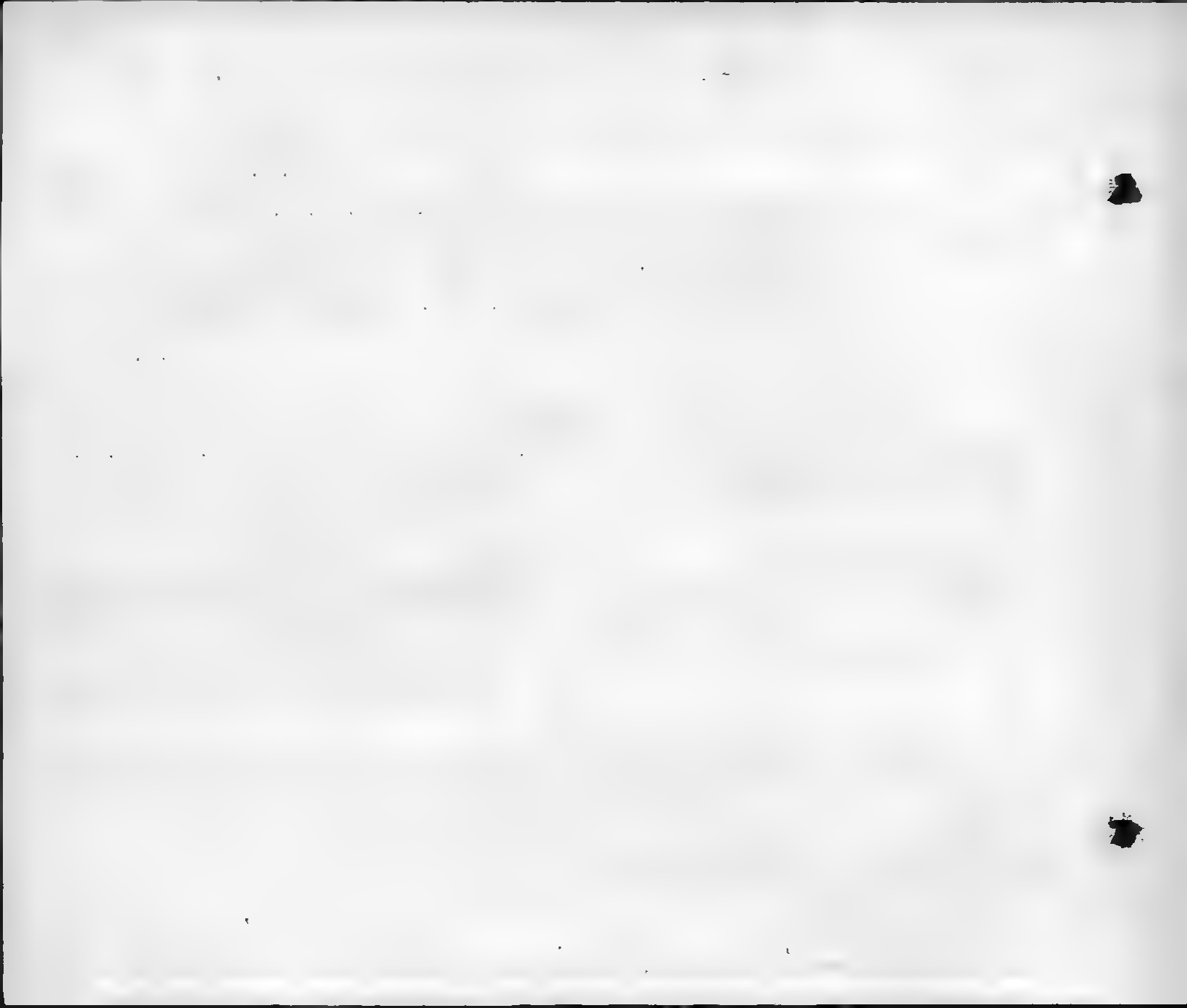
CERTIFICATE OF DEATH

11498

Reg. Dist. No.

11447

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery County</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>Washington, D.C.</b> |   |
| c. LENGTH OF STAY IN 1b<br><b>41X-2</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cedar Haven Rest Home, 7300 Balti Ave</b>   |  | d. STREET ADDRESS<br><b>3614 Conn. Ave. N.W.,</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>LIURA V. HOUSER</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Oct 17 1958</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>Feb. 16th., 1882</b>                                 |
| 9. AGE (In years last birthday)<br><b>76 yrs.</b>  |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min<br><b>8 1</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>John Upton</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Codrick</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Mrs. Herbert King</b>  |  | Address<br><b>3614 Conn. Ave N. W.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure -</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease.</b><br>DUE TO (c) <b>Hypertension &amp; Atherosclerosis.</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>2 years</b><br><b>4 years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Aug. 15, 1958</b> to <b>Oct. 17, 1958</b> , that I last saw the deceased alive on <b>Oct. 16, 1958</b> , and that death occurred at <b>4:55 PM</b> , from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE<br><b>Neil P. Campbell</b>  |  | M.D. <b>Kenesaw apt</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Neil P. CAMPBELL</b>   |  | DATE SIGNED<br><b>10/17/58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-20-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Columbia Gardens</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ives Funeral Home</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |   |
| By: <b>C. M. Jones</b> 2847 Wilson Blvd. Arlington, Virginia   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 21 '58</b>  |   |



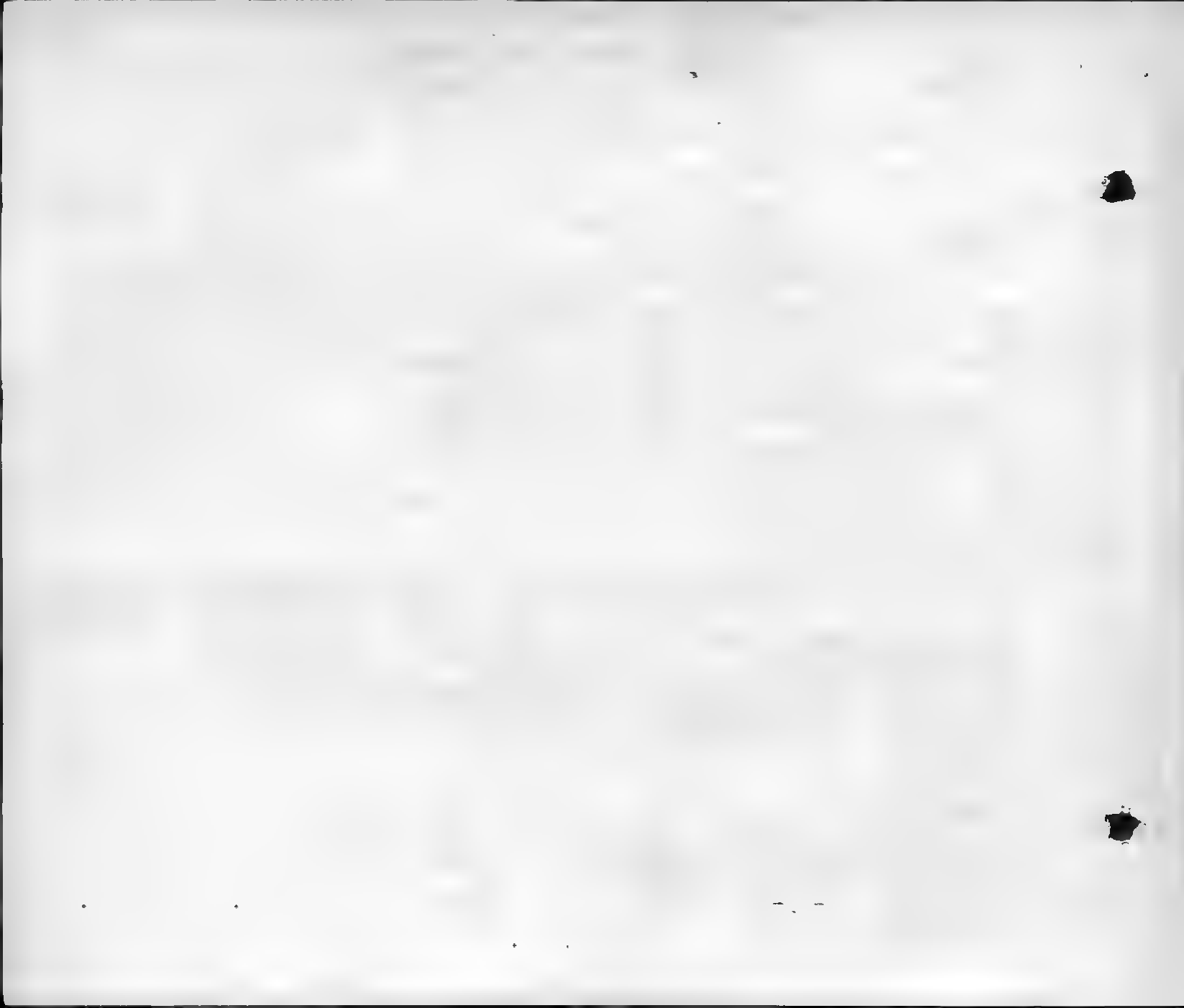
11521 CERTIFICATE OF DEATH

11499

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>o COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |   | c. LENGTH OF STAY IN 1b<br><u>9 days</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Suburban Hospital</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Margaret</u> Middle <u>Taylor</u> Last <u>Hunter</u>   |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>10</u> Year <u>1958</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>August 25, 1884</u>   |
| 9. AGE (In years last birthday)<br><u>74</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>   | 11. IF UNDER 24 HRS<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Highlands of Scotland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>Britain</u> ✓   |  |
| 13. FATHER'S NAME<br><u>John Robertson</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Margaret McGregor</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>  </u>  |  |
| 17. INFORMANT<br><u>Daughter</u>   |   | Address<br><u>Dorothy Monro Hunter</u> Same as above   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>44.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u><br>DUE TO<br>(c) <u>Arteriosclerotic Heart Disease</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u><br><u>10 days</u><br><u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u><br>Month <u>  </u> Day <u>  </u> Year <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>58</u> , to <u>10/10</u> , 19 <u>58</u> that I last saw the deceased alive on <u>10/9</u> , 19 <u>58</u> , and that death occurred at <u>125</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |   |  |  |
| ACTUAL SIGNATURE<br><u>Alvin I Kay</u>   |   | M.D. <u>1835 Eye St NW.</u> <u>10/10/58</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>ALVIN I KAY MD</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  | 22b. DATE THEREOF<br><u>10-13-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Prince Geo. County, Md.</u>      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>ROBERT A. PUMPHREY</u>  |   | ADDRESS<br><u>Bethesda, Md.</u>  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 14 '58</u>                                    |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Chas S. Harris</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11560

Item 1 Will. 234 10-16-58 et  
11522 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>4807 Marwood Lane</u><br><u>Montgomery Co.</u> MARYLAND                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>4807 Marwood Lane S.S.M.</u><br>b. COUNTY <u>Silver Spring Md</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring Md</u><br>d. STREET ADDRESS <u>Own home</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring Md</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring Md</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Own home</u>             |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Le Roy</u> Last <u>Huntington</u>              |                                  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>1</u> Year <u>1958</u>   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 11 1900</u>  |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>  | 11. IF UNDER 24 HRS<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Printing Press</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Supermarket</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Wash. D.C.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>George Huntington</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mrs Mary Huntington</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>No</u>                                       |                                  | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  |
| 17. INFORMANT<br><u>Mrs Mary Huntington</u>  |                                  | Address<br><u>Mc Culloch</u>  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>DUE TO (b) <u>Coronary Heart Disease</u><br>DUE TO (c) <u>—</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>11 hours</u><br><u>3 yrs.</u> |
|--|--|--|

|  |  |   |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Essential Hypertension</u> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u><br>p. m. <u>—</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

|   |                               |
|---|-------------------------------|
| 21. I certify that I attended the deceased from <u>Aug. 14, 1957</u> to <u>Oct. 1, 1958</u> , that I last saw the deceased alive on <u>Oct. 1, 1958</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. |                               |
| ACTUAL SIGNATURE<br><u>Thomas J. Kelly</u> M.D. <u>6480 N. H. Ave</u>   | DATE SIGNED<br><u>10/1/58</u> |
| PHYSICIAN'S NAME (Type)<br><u>THOMAS J. KELLY M.D. Takoma Park, Md</u>  |                               |

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10/1/58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State)<br><u>Montgomery Co. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm J. Huntington</u> |                                     | 24a. REC'D BY REGISTRAR<br><u>—</u>                     | 24b. REGISTRAR'S SIGNATURE<br><u>—</u>                                     |
| ADDRESS<br><u>3732 Arden</u>                                |                                     | DATE<br><u>OCT 3 '58</u>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

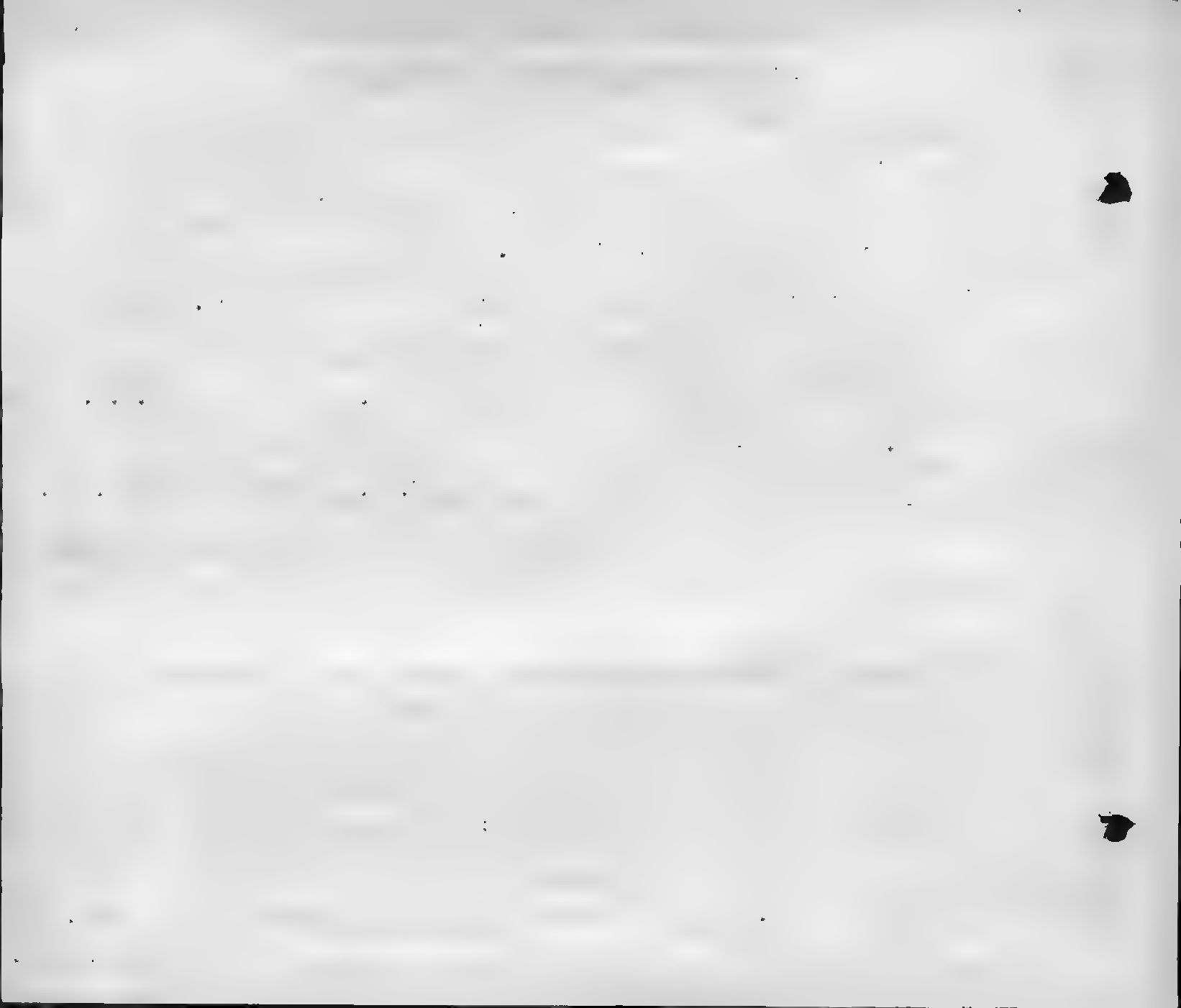
11501

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

11523

|  |                                  |  |   |   |   |   |                                |
|--|----------------------------------|--|---|---|---|---|--------------------------------|
| 1. PLACE OF DEATH  |                                  |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED   |   |   |                                |
| COUNTY <b>Montgomery</b>   |                                  | STATE <b>Maryland</b>  |   | COUNTY <b>Montgomery</b>  |   |   |                                |
| CITY (if outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Olney</b>   |                                  | LENGTH OF STAY (in this place)<br><b>2 Month</b>   |   | CITY (if outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Brinklow</b> |   |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Brooke Grove Chronic Hosp.</b>  |                                  |  |   | STREET ADDRESS (if rural give location)   |   |   |                                |
| 3. NAME OF DECEASED (Type or Print)  |                                  |  |   | 4. DATE OF DEATH  |   |   |                                |
| (First) <b>William</b> (Middle) <b>A</b> (Last) <b>Iddings</b>   |                                  |  |   | (Month) <b>Oct.</b> (Day) <b>31</b> (Year) <b>19 58</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>  | 8. DATE OF BIRTH<br><b>June 16 1866</b> | 9. AGE last birthday<br><b>92</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Hanger</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building Repair</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                   |                                |
| 13. FATHER'S NAME<br><b>C. Edward Iddings</b>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Harriett Retzer</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT & ADDRESS<br><b>Mrs J. A. Willson, Brinklow, Md.</b>                                  |   |   |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |  |   |   |   | 18. MEDICAL CERTIFICATION                                       |                                |
| IMMEDIATE CAUSE (A) <b>Uremia</b>  |                                  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>               |                                |
| ANTECEDENT CAUSE(S) DUE TO <b>Chronic Interstitial Nephritis</b>   |                                  |  |   |   |   | <b>years</b>  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Arterio-sclerosis</b>  |                                  |  |   |   |   |   |                                |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                  |  |   |   |   |   |                                |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |   |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |   |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <b>2/1/</b>   |                                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |   |   |                                |
| 22. I hereby certify that I attended the deceased from <b>2/1/</b> , 19 <b>57</b> , to <b>Oct. 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/26/</b> , 19 <b>58</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. |                                  |  |   |   |   |   |                                |
| SIGNATURE <b>[Signature]</b>   |                                  | M.D. <b>Sandy Spitz</b>  |   | ADDRESS (Street, city, town, state)<br><b>Brinklow Md.</b>  |   | DATE SIGNED<br><b>11/1/58</b>                                   |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                                  | DATE THEREOF<br><b>Nov. 4</b>  |   | NAME OF CEMETERY OR CREMATORY<br><b>Woodside</b>  |   | LOCATION (City, town, or county) (State)<br><b>Brinklow Md.</b> |                                |
| 24. REC'D BY REGISTRAR   |                                  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Roy W. Barker</b>  |   | ADDRESS<br><b>Laytonsville, Md.</b>                             |                                |
| DATE <b>NOV 5 '58</b>  |                                  |  |   |   |   |   |                                |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

11524

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b<br><u>16 days</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>   |  |   | d. STREET ADDRESS<br><u>3621 39th St. N.W.</u>  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Earl</u> Middle <u>—</u> Last <u>Inghalls</u>   |  |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>25</u> Year <u>1958</u>   |   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 27-86</u>  |   | 9. AGE (In years last birthday)<br><u>72</u> yrs                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>milk deliverman - labor</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>New York</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |   |
| 13. FATHER'S NAME<br><u>Augusta Inghalls</u>  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Martha Dykemun</u>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>084-03-7024</u>   |   | 17. INFORMANT<br><u>Edith Inghalls - same address</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u><br><u>403.0</u> DUE TO (b) <u>Pulmonary edema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Fracture left hip</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>47</u> |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hr</u><br><u>3 days</u><br><u>17 days</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Fell on floor at home</u>                                  |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>10</u> <u>28</u> <u>1958</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   |   | 20f. (City or town) (County) (State)<br><u>Washington</u> <u>D.C.</u>                                 |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |   |   |   |
| ACTUAL SIGNATURE<br><u>Frank J. Broschant</u>   |  | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED<br><u>10-26-58</u>  |   |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschant</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |
| 22a. BURIAL CREMATION REMOVAL (Specify)<br><u>Removal</u>   | 22b. DATE THEREOF<br><u>10-28-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>FERNCLIFF CEMETERY</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>HARTSDALE, NEW YORK</u>                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph Sewlin Sons</u>   |  | ADDRESS<br><u>Wash. D.C.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>ACT 2 3 '58</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                                |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11448

## CERTIFICATE OF DEATH

11503

Reg. Dist. No.

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park</u>   |                                       |
| c. LENGTH OF STAY IN b. <u>years</u>   |                               | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7111 Holly Avenue</u>  |                                       |
| d. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>SHOFFNER</u> Last <u>JACKSON</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>SHOFFNER</u> Last <u>JACKSON</u>   |                               | 4. DATE OF DEATH Month <u>OCT</u> Day <u>2</u> Year <u>1958</u>  |                                       |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 10, 1880</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Acton, Penna</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                       |
| 13. FATHER'S NAME <u>John Shoffner</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Victoria Zerbe</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u></u>  |                                       |
| 17. INFORMANT <u>Mrs. Mary C. Auld</u> Address <u>7111 Holly Ave. T.B. Md.</u>   |                               |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                               |  |                                       |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>  |                               |  |                                       |
| DUE TO <u>331X</u>   |                               |  |                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u>  |                               |  |                                       |
| DUE TO (c) <u></u>   |                               |  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                               |  |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <u>13 July</u> , 1958, to <u>2 Oct</u> , 1958, that I last saw the deceased alive on <u>1 Oct</u> , 1958, and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. |                               |  |                                       |
| ACTUAL SIGNATURE <u>H.B. Queen</u> M.D. <u>7112 Willow Ave</u>   |                               | DATE SIGNED <u>3 Oct</u>   |                                       |
| PHYSICIAN'S NAME (Type) <u>H.B. Queen</u>  |                               | ADDRESS (Street, city or town, state) <u>Takoma Park Md</u>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>Oct. 6, 1958</u>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Roanoke Virginia</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Walters</u> ADDRESS <u>254 Carroll St NW DC</u>  |                               | 24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>  |                                       |
| 24b. REGISTRAR'S SIGNATURE <u>C. H. S. Reed</u>  |                               |  |                                       |



11525

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>70 days</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br><b>Oklahoma</b><br>b. COUNTY<br><b>Norman</b>            |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>U. S. Naval Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Jules Winford JOHNSON</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 27 1958</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 18, 1918</b> |
| 9. AGE (In years last birthday)<br><b>40</b> yrs  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  | 11. IF UNDER 24 HRS                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mariner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Navy</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Mississippi</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Edgar JOHNSON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Fanny POWERS</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or datum of service)<br><b>Yes WWII-Korean</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>409-22-1879</b>   |   |
| 17. INFORMANT<br><b>(W) Mrs. G. Johnson, 1821 Driftwood, Memphis, Tenn.</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Metastasis</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Brain metastasis from carcinoma of the prostate</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>August 18, 1958</b> , to <b>October 27, 1958</b> , that I last saw the deceased alive on <b>October 27, 1958</b> , and that death occurred at <b>10:51A M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>U. S. Naval Hospital, NNMC 10-27-58</b>  |                                  |   |   |
| ACTUAL SIGNATURE <b>AT Thorp</b>  |                                  | M.D. <b>U. S. Naval Hospital, NNMC</b>  |   |
| PHYSICIAN'S NAME (Type) <b>A. T. THORP, JR., LT, MC, USN</b>  |                                  | <b>BETHESDA 14, MARYLAND</b>  |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Ernest A. Adams</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Tennessee</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Adams Funeral Home, 4748 Wisc. Ave., NW, Wash., DC</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 30 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11526

## CERTIFICATE OF DEATH

11505

Reg. Dist. No.

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                                   | c. LENGTH OF STAY IN 1b <u>3 da.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Hershey Johnson</u>   |                                   | 4. DATE OF DEATH Month Day Year <u>Oct. 26 1958</u>  |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 6 1894</u>                                 |
| 9. AGE (In years last birthday) <u>64</u> yrs.  |                                   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min <u>1 20</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>  |   |
| 13. FATHER'S NAME <u>Edward R. Johnson</u>  |                                   | 14. MOTHER'S MAIDEN NAME <u>Laura Helen Hershey</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                                   | 16. SOCIAL SECURITY NO <u>None</u>   |   |
| 17. INFORMANT <u>Zelma M. Johnson</u>   |                                   | Address <u>Rockville Md. 1003 DeBeck Dr.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>terminal heart failure</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Subendocardial Myocardial Infarction</u><br>DUE TO <u>Coronary Arteriosclerosis, Senile</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific Aortic Stenosis</u> |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u><br><u>Unknown</u>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd, Rockville</u> DATE SIGNED <u>10/26/58</u>   |                                   |  |   |
| ACTUAL SIGNATURE <u>Herman Maganzini</u> M.D.   |                                   | 809 Viers Mill Road, Rock. Md.   |   |
| PHYSICIAN'S NAME (Type) <u>Herman Maganzini, M.D.</u>   |                                   | 809 Viers Mill Road, Rock. Md.   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>  | 22b. DATE THEREOF <u>10/29/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Piquette, Ohio</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>  |                                   | ADDRESS <u>Bethesda, Maryland</u>  |   |
| 24a. REC'D BY REGISTRAR <u>Oct 28 '58</u>   |                                   | 24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20b Film 255-1-58-58 and

11527

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11506

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>   |  | d. STREET ADDRESS <b>3629 13th St N.W.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Allen</b> Middle <b>Derry</b> Last <b>Jones</b>  |  | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>27</b> Year <b>1958</b>  |   |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>COL</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>9/5/05</b>  |
| 9. AGE (In years last birthday) <b>53</b> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Rockville</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   |
| 13. FATHER'S NAME <b>Allen Jones</b>   |  | 14. MOTHER'S MAIDEN NAME <b>?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>579-382830</b>  |   |
| 17. INFORMANT <b>K. Star Baker</b>   |  | Address <b>3629 13th St N.W. Wash. D.C.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |   |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thrombosis hemorrhage</b>  |  |  |   |
| 850X DUE TO  |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Rupture of heart</b>   |  |  |   |
| (c) <b>Crushed chest</b>   |  |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Truck backed over body</b>                                |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>10:40</b> <b>10-27</b> <b>1958</b>  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Stone pit</b>  | 20f. (City or town) <b>Rockville</b> (County) <b>Montgomery</b> (State) <b>MD</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <b>Frank J. Brunkert</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>Oct 31 1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>   |  | 22d. LOCATION (City, town, or county) <b>Washington, D.C.</b> (State)  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Fraser Funeral Home, Inc</b>   |  | 24a. REC'D BY REGISTRAR <b>Oct 29 '58</b>  |   |
| ADDRESS <b>389-R. E. Ave. N.W.</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>C. J. E. Thomas</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



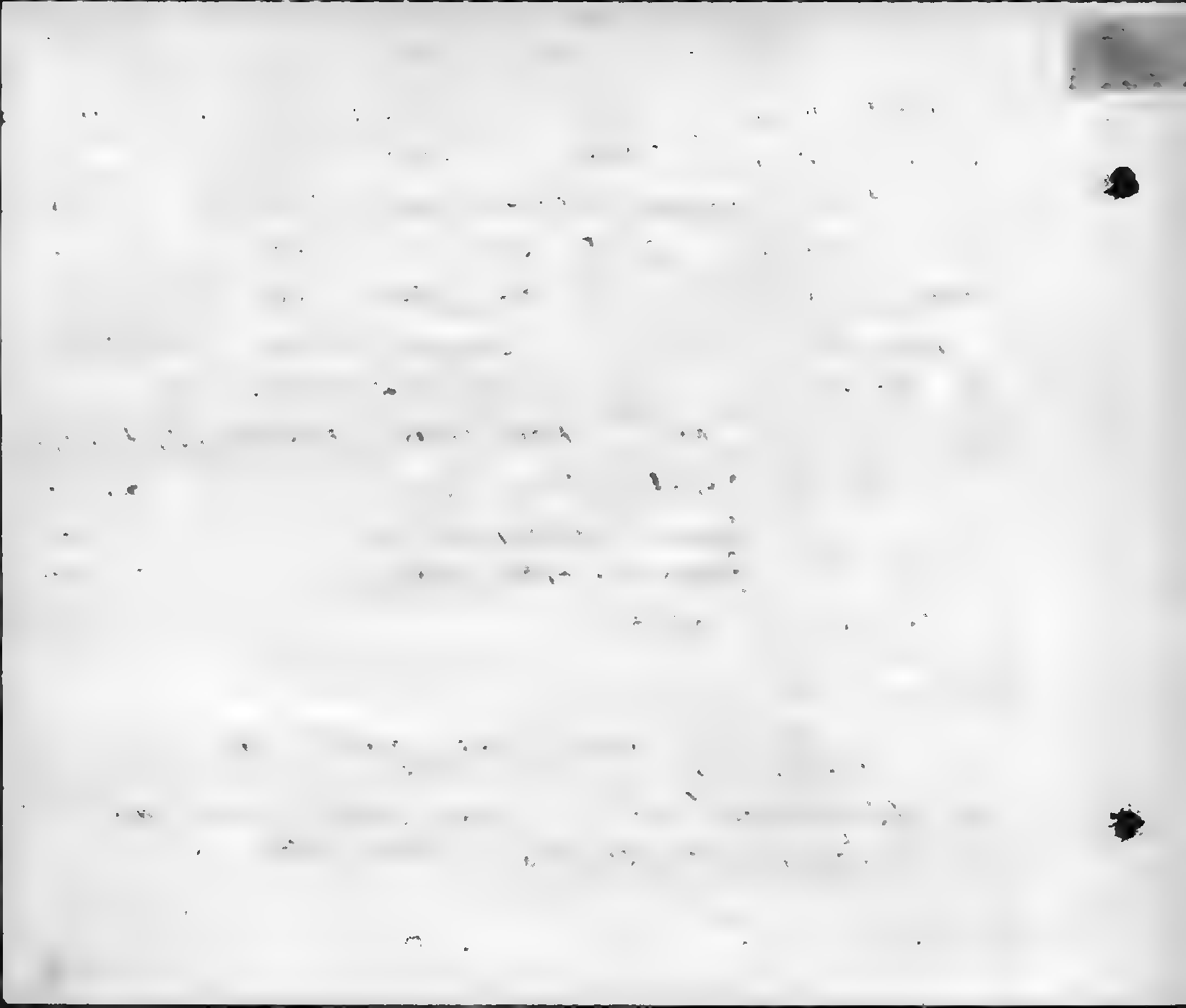
11528

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                      |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Althea Woodland Nursing Home</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Mrs. Jocelyn B. E. Jones</u>   |                               | 4. DATE OF DEATH <u>Oct. 4, 1958</u>   |                                      |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 11, 1869</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs.  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>11</u> Days <u>4</u> Hours <u>1</u> Min <u>0</u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><u>Indiana, U. S. A.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>   |                                      |
| 13. FATHER'S NAME<br><u>Dr. James C. Lemir</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>MARY L. FURNACE</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                      |
| 17. INFORMANT <u>Arthur Dillon - #4 Parker Rd. Silver Spring</u>  |                               | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO <u>Generalized Arteriosclerosis</u><br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>10 years</u><br><u>20 years</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Arteriosclerosis</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a. m.</u> <u>19</u> p. m.   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <u>July 14, 1958</u> to <u>Oct. 4, 1958</u> , that I last saw the deceased alive on <u>Oct. 2, 1958</u> , and that death occurred at <u>3:00 p. m.</u> from the causes and on the date stated above.  |                               |  |                                      |
| ACTUAL SIGNATURE <u>R. Stephen Hulbert</u>  |                               | ADDRESS (Street, city or town, state) <u>3000 Dent Place NW, Washington, D.C.</u>  |                                      |
| PHYSICIAN'S NAME (Type) <u>R. Stephen Hulbert, MD</u>   |                               | DATE SIGNED <u>Oct. 4, 1958</u>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>10/7/58</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska, Inc.</u>  |                               | 24a. REC'D BY REGISTRAR <u>OCT 7 58</u>  |                                      |
| ADDRESS <u>Silver Spring, Md.</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>W. L. Knaus</u>  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

11529 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |   |  |                 |
|---|----------------------------------|---|--|---|---|--|-----------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY |   |  |                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>COLESVILLE</b>   |                                  |   |  | c. LENGTH OF STAY IN 1b   |   |  |                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MARILEA NURSING HOME</b>   |                                  |   |  | e. STREET ADDRESS<br><b>3702 CLIPPER ROAD</b>   |   |  |                 |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>WALTER L. KAIN</b>  |                                  |   |  | 4. DATE OF DEATH Month Day Year<br><b>Oct 28, 1958</b>  |   |  |                 |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 17, 1894</b> | 9. AGE (In years last birthday)<br><b>64</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. NAVY</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?   |                 |
| 13. FATHER'S NAME<br><b>GEORGE W. KAIN</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>EMILY L. KAIN</b>  |   |  |                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES 1ST &amp; 2ND WW</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>-</b>  |  | 17. INFORMANT Address<br><b>GEORGE W. KAIN 3702 CLIPPER ROAD</b>  |   |  |                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                                  |   |  |   |   |  |                 |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 20 min<br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO<br>(c) |                                  |   |  |   |   |  |                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |                                  |   |  |   |   |  |                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                          |   |  |                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                                  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work          |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                 |
| 20f. (City or town) (County) (State)  |                                  |   |  |   |   |  |                 |
| 21. I certify that I attended the deceased from <b>Sept 3, 1958</b> to <b>Oct 28, 1958</b> , that I last saw the deceased alive on <b>Oct 27, 1958</b> , and that death occurred at <b>9:15 M.</b> from the causes and on the date stated above.                      |                                  |   |  |   |   |  |                 |
| SIGNATURE<br><b>Paul E. Schenck</b> M.D.  |                                  |   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>1719 Lemmon Rd., BALTO., 10-28-58</b>                         |   |  |                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>Oct 31, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTO.</b>         |                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul E. Schenck</b> ADDRESS<br><b>3617 Chestnut Ave</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 31 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                   |                 |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2 37

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11530

11509

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>M</u><br>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN TB <u>DOA</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u><br>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>26 Rockville</u><br>d. STREET ADDRESS <u>1013 Rockcrest Dr.</u><br>e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Betty Gaye Kidwell</u><br>First Middle Last<br>4. DATE OF DEATH <u>Oct. 25, 1958</u><br>Month Day Year   |  | 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Feb 1, 1941</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>17</u> yrs. <u>8</u> months <u>24</u> days<br>IF UNDER 24 HRS. Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk &amp; student</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>store</u><br>11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>Warren Kidwell</u><br>14. MOTHER'S MAIDEN NAME <u>Aileen Horning</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u><br>(If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO. <u>unknown</u><br>17. INFORMANT <u>Aileen Poole Mother</u><br>Address <u>Item 2</u>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br><u>825X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of skull</u><br>DUE TO (c) <u>sudden</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>passenger in auto accident</u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>10/28/58</u><br>Hour <u>6:30</u> a.m. p.m.<br>20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rockville Montg. Md.</u><br>20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschatt</u><br>EXAMINER'S NAME (Type) <u>Frank J. Broschatt</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/26/58</u><br>DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>22b. DATE THEREOF <u>10/28/58</u><br>22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u><br>22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u><br>ADDRESS <u>Bethesda, Maryland</u>   |  | 24a. REC'D BY REGISTRAR <u>Oct 27 '58</u><br>24b. REGISTRAR'S SIGNATURE <u>Arthur P. Kraus</u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11531

## CERTIFICATE OF DEATH

11510

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Iva</u> Middle <u>Catharine</u> Last <u>Lewis</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>30</u> Year <u>1958</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb-20-1896</u>                               |
| 9. AGE (In years last birthday) <u>62</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>8</u> Days <u>30</u> Hours <u></u> Min <u></u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>house-keeping</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Eagan Finkbe</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Gertrude Elizabeth Walker</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO. <u>219-163632</u>  |  |
| 17. INFORMANT <u>Wm. T. Lewis, 7 Brooks Ave., Gaithersburg, Md</u>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure (Myocardial)</u><br>182. + DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u><br>DUE TO (c) <u></u> |                                  | INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u> p. m. <u></u>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Oct-14-1958</u> to <u>Oct-30-1958</u> , that I last saw the deceased alive on <u>Oct-29-1958</u> , and that death occurred at <u>8-13</u> A.M., from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>William C. Miller</u> M.D.  |                                  | DATE SIGNED <u>7-Brooks Ave.,</u>  |  |
| PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>  |                                  | ADDRESS (Street, city or town, state) <u>Gaithersburg, Md.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>11-1-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>   | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Farnum, Gaithersburg, Md</u>  |                                  | 24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>   |  |
| ADDRESS <u>Gaithersburg, Md</u>   |                                  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farnum</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11532

## CERTIFICATE OF DEATH

11511

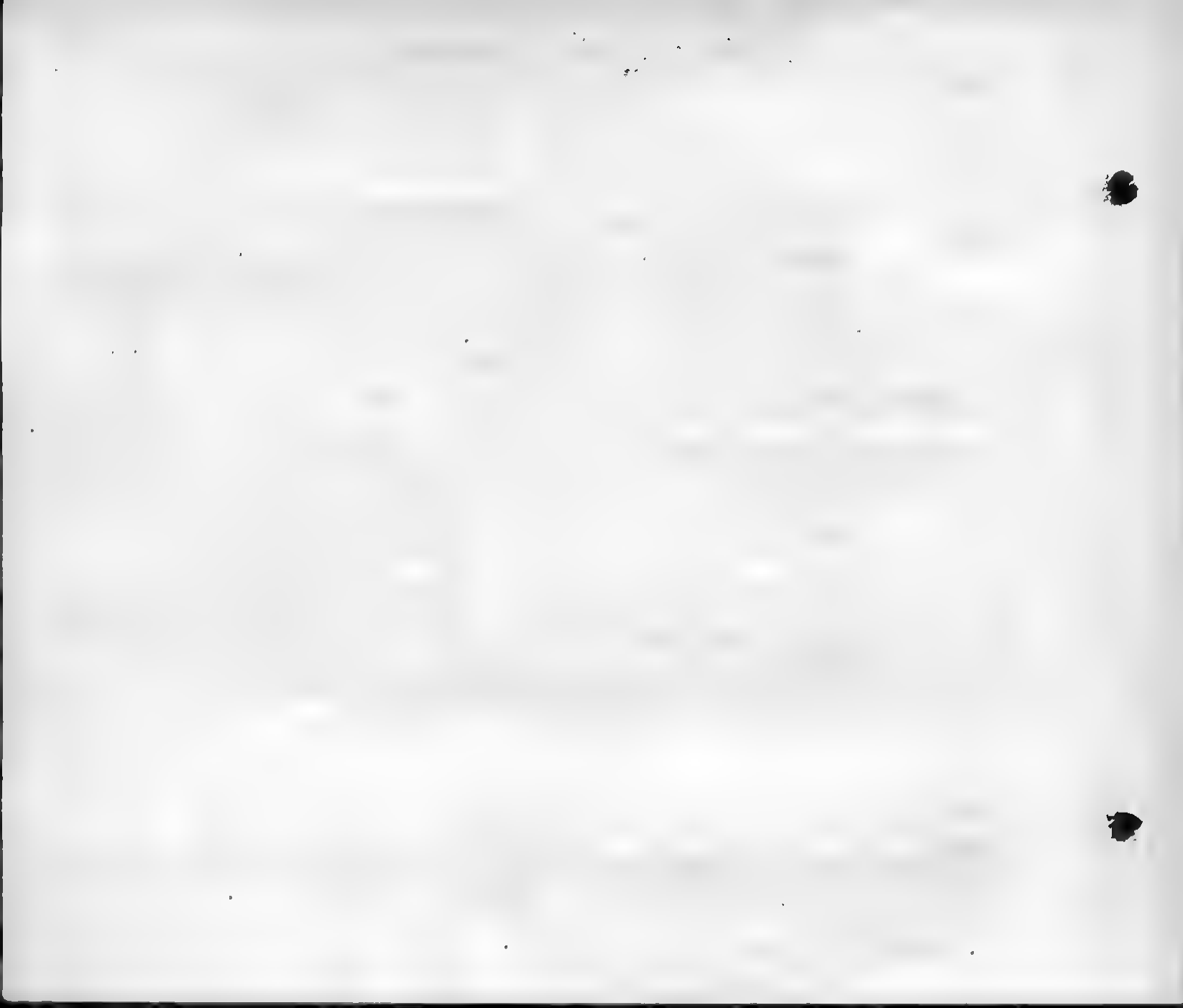
Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>b. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>   |  |   |  | c. LENGTH OF STAY IN TB<br><b>3 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SUBURBAN</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HYATTSVILLE</b>  |  |  |  |
| d. STREET ADDRESS<br><b>8507 Nicholson St.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>J.</b> Last <b>LOCKHART</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>15</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 8. DATE OF BIRTH<br><b>6/27/19</b>                                     |  |
| 9. AGE (In years last birthday)<br><b>39</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 2 YEARS<br>Months Days Hours Min.  |  | IF UNDER 5 YEARS<br>Months Days Hours Min.                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Electronic Engineer</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>National Security</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>George Lockhart</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lucy Ware</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes Army</b>   |  |   |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| 17. INFORMANT<br><b>Wife</b>  |  |   |  | Address<br><b>Mrs Florence Lockhart Hyattsville Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>stroke</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>subtotal gastrectomy</b><br>DUE TO<br>(c) <b>intestinal ulcer obstruction</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)<br>(County)<br>(State)  |  |   |  | 20g. (City or town)<br>(County)<br>(State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>Oct 12/58</b> 19 <b>58</b> to <b>Oct 15</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 15/58</b> 19 <b>58</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>John O. Ralston</b>  |  |   |  | ADDRESS (Street, city or town, state)<br><b>2930 Georgia Ave S.W. Wash D.C.</b>   |  |  |  |
| DATE SIGNED<br><b>Oct 21 58</b>   |  |   |  | DATE<br><b>Oct 21 58</b>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>F. Gasch's Sons</b>   |  |   |  | ADDRESS<br><b>Hyattsville, Maryland.</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 22b. DATE THEREOF<br><b>Oct 20, 1958</b>  |  |  |  |
| 22c. NAME OF CEMETERY<br><b>Arlington National</b>  |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Va.</b>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>  |  |   |  | 24. REC'D BY REGISTRAR<br><b>Oct 21 58</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>James S. Hearn</b>   |  |   |  | 24c. REGISTRAR'S SIGNATURE<br><b>James S. Hearn</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11449

## CERTIFICATE OF DEATH

Reg. Dist. No. 11512

|   |                               |  |   |  |   |  |  |
|---|-------------------------------|--|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                               |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>  |                               |  |   | d. STREET ADDRESS <u>102 Park Ave.</u>   |   |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Smull</u> Last <u>Longacre</u>   |                               |  |   | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1958</u>  |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/1/71</u>                 | 9. AGE (In years last birthday) <u>86</u> yrs.   | IF UNDER 1 YEAR Months Days Hours Min.                                    |  | IF UNDER 24 HRS                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>   |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY               |  | 11. BIRTH-PLACE (State or foreign country) <u>Pennsylvania</u>            |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Henry W. Longacre</u>  |                               |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Smull</u> |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                               |  | 16. SOCIAL SECURITY NO.                         |  | 17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital Records</u> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <u>coronary</u>  |                               |  |   |  |   |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Occlusion (2<sup>nd</sup> attack)</u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>  |                               |  |   |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>known Right Bundle Branch Block of heart</u> <u>for years</u>   |                               |  |   |  |   |  |  |
| (c) <u>Carcinoma Colon-splenic flexure</u> <u>1 year ±</u>  |                               |  |   |  |   |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgery - right hemi-colectomy &amp; hysterectomy; shock</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |   |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 16)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |                               |  |   | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
| 20f. (City or town) (County) (State)  |                               |  |   | 21. I certify that I attended the deceased from <u>10-14-</u> 19 <u>58</u> , to <u>10-23-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10-23-</u> 19 <u>58</u> , and that death occurred at <u>3:40 P.</u> M, from the causes and on the date stated above. |   |  |  |
| ACTUAL SIGNATURE <u>Ad N. Calvert</u>   |                               |  |   | ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., Silver Spring, Md.</u> DATE SIGNED <u>10-23-58</u>   |   |  |  |
| PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>  |                               |  |   | <u>7894 Georgia Ave., Silver Spring, Md.</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |                               | 22b. DATE THEREOF <u>OCT. 27, 1958</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hall</u>  |                               |  |   | ADDRESS <u>Takoma Park, D.C.</u>   |   | 24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>                             |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur H. Hall</u>  |                               |  |   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsertion papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11533

## CERTIFICATE OF DEATH

11513

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>o STATE <u>West Virginia</u> b. COUNTY                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>56 days</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>The Clinical Center, Bethesda 14, Md.</u>  |                                  | d. STREET ADDRESS<br><u>4219 River Avenue</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edgar</u> Middle <u>Mathes</u> Last <u>Lore</u>   |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>9</u> Year <u>19 58</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>20 September 1908</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chemical Operator</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Chemical</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>William A. Lore</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Nora Cusingberg</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>235-01-6572</u>  |  |
| 17. INFORMANT<br><u>The Medical Record</u>  |                                  | Address<br><u>The Clinical Center, Bethesda 14, Maryland</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Right Pleural Effusion with Mediastinal Shift</u><br><u>190.9</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.<br>(b) <u>Malignant Melanoma</u><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo.</u><br><u>8 months</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>August 14</u> , 19 <u>58</u> , to <u>October 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 9</u> , 19 <u>58</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>The Clinical Center</u> <u>10/10/58</u><br>NATIONAL INSTITUTES OF HEALTH<br><u>Bethesda 14, Maryland</u>  |                                  |   |  |
| ACTUAL SIGNATURE<br><u>Harold R Silberman</u> M.D.  |                                  | PHYSICIAN'S NAME (Type)<br><u>HAROLD R. SILBERMAN, M.D.</u>   |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>10/13/58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Memorial</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>S. Charleston, W. Va.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |                                  | ADDRESS<br><u>Bethesda, Maryland</u>  |  |
| 24a. REC'D BY REGISTRAR<br><u>OCT 14 '58</u>  |                                  | 24b. REGISTRAR'S SIGNATURE  |  |



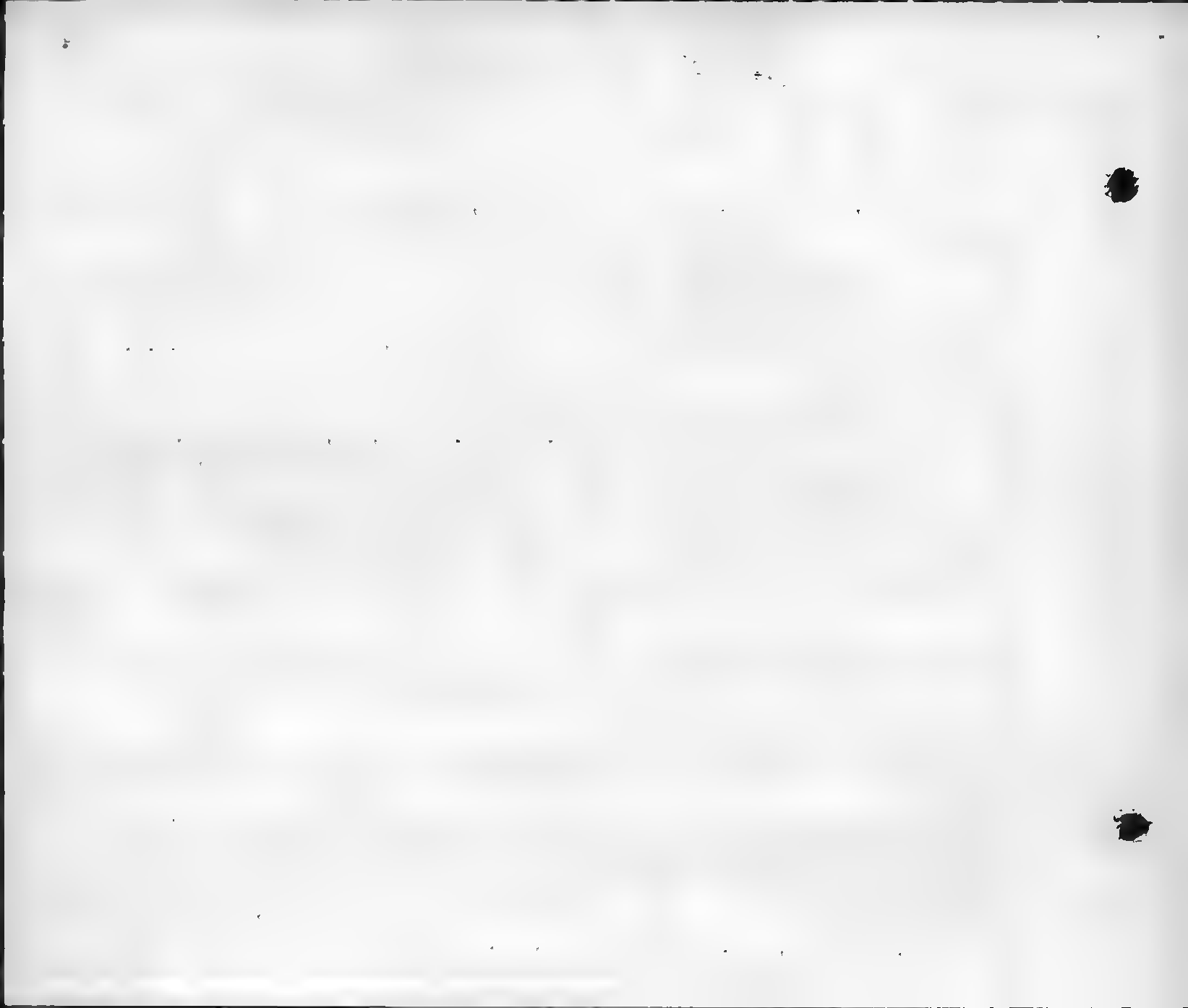
## 11534 CERTIFICATE OF DEATH

11514

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>7 years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>12,820 BAKER DRIVE</b>  |  |  |  | e. STREET ADDRESS<br><b>12,820 BAKER DRIVE</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOUISE</b> Middle <b>CAROLINE</b> Last <b>LUTES</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>26</b> Year <b>19 58</b>  |  |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>         |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/27/75</b>  |  |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>BEALLSVILLE, OHIO</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>CHARLES FORNI</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>DENA FREUDIGER</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>Mr. Fred L. Lutes, 12,820 Baker Dr.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br><b>402.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Degeneration</b><br>DUE TO (c) <b>Generalized Arterio Sclerosis</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years 10 4 cars</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. — 19<br>p. m. —  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town)  |  |  |  | 20g. (County)   |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <b>January 1948</b> , to <b>OCT 26, 1958</b> , that I last saw the deceased alive on <b>October 24, 1958</b> , and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Merrill M. Cross</b>  |  |  |  | ADDRESS (Street, city or town, state)<br><b>8248 COLEVILLE, SILVER SPRING, MD.</b>  |  |  |  |
| DATE SIGNED<br><b>10/26/58</b>   |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>MERRILL M. CROSS</b>   |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>10/29/58</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>COLESVILLE CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>COLESVILLE, MARYLAND</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b>  |  |  |  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 '58</b>                            |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. Francis</b>  |  |  |  |   |  |  |  |

1. HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11535 CERTIFICATE OF DEATH

Reg. Dist. No. 11515

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |  |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Althea Glen Nursing Home</b><br><b>9301 Weaver St.</b>  |  |  |  | e. STREET ADDRESS<br><b>3911 Washington</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Burtas</b> Middle <b>Russell</b> Last <b>MacHatton</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>7</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>                                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/31/1870</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.   |  | IF UNDER 1 YEAR: Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min. |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Minister of the Gospel</b>                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ohio</b>                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 13. FATHER'S NAME<br><b>Joseph MacHatton</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Hare</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Nursing Home Records—same as "d"</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>   |  |  |  |  |  |   |  |
| DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b>   |  |  |  |  |  |   |  |
| DUE TO (c) <b>Emphysema Pulmonary, Carcinoma Squamous Cell Lung</b>   |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |
| 20a. ACCIDENT IT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY<br>Month <b>10</b> Day <b>7</b> Year <b>1958</b><br>Hour <b>a. m.</b> p. m.   |  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town)   |  |  |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <b>May 1958</b> to <b>7 Oct 58</b> that I last saw the deceased alive on <b>6 Oct 58</b> , and that death occurred at <b>3:15 A. M.</b> from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas P. Fogarty</b>   |  |  |  | ADDRESS (Street, city or town, state)<br><b>1011 University Blvd. Silver Spring, Md.</b>   |  |   |  |
| DATE SIGNED   |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>10/9/58</b>                                |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Graceland Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Chicago, Illinois</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co. Washington, D. C.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>C. Thur S. Kraus</b>                     |  |

1901

George Washington

The first of the great men of the world  
was born on the 22nd of February 1732  
at Westmoreland, Virginia.

He was a great man  
and a great leader  
of his people.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11536 CERTIFICATE OF DEATH

11516

Reg. Dist. No.

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Prince Georges</b>     |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                               | c. LENGTH OF STAY IN lb <b>174 days</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>  |                               | d. STREET ADDRESS <b>5107 72nd Avenue</b>  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Henry Renshaw Magruder Jr.</b>  |                               | 4. DATE OF DEATH <b>October 30 1958</b>  |                                       |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>July 29, 1929</b> |
| 9. AGE (In years last birthday) <b>29</b> yrs  |                               | 10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>  | 11. IF UNDER 24 HRS                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeping</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>  |                               | 12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>  |                                       |
| 13. FATHER'S NAME <b>Henry R. Magruder, Sr.</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Agnes Foley</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                               | 16. SOCIAL SECURITY NO <b>577-34-2995</b>  |                                       |
| 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |                               |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Staphylococcal Pneumonia and Septicemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b><br>DUE TO (c) |                               | INTERVAL BETWEEN ONSET AND DEATH <b>days</b><br><b>2 1/4 years</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>May 9 1958</b> to <b>October 30 1958</b> , that I last saw the deceased alive on <b>October 30 1958</b> , and that death occurred at <b>6:25 P. M.</b> from the causes and on the date stated above   |                               |  |                                       |
| ACTUAL SIGNATURE <b>Arthur L. Teplitzky</b> M. D.  |                               | ADDRESS (Street, city or town, state) <b>The Clinical Center</b>   |                                       |
| NAME (Type) <b>Arthur L. Teplitzky, M. D.</b>  |                               | DATE SIGNED <b>10/31/58</b>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Nov 3, 1958</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>   |                                       |
|  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Teplitzky</b>  |                                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11537 CERTIFICATE OF DEATH

11517

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Dist. of Columbia</u> b. COUNTY                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA (RURAL)</u>   |   | c. LENGTH OF STAY IN 1b<br><u>1 yr 11 months</u>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington 5. D.C.</u>   |   | d. STREET ADDRESS<br><u>1301 - 15th St. N.W.</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>RESMOR SANATARIUM Hospital</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>LEWIS</u> Middle Last <u>MARKS</u>  |   | 4. DATE OF DEATH<br>Month <u>10</u> - Day <u>30</u> - Year <u>1958</u>  |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JULY 22, 1884</u>  |
| 9. AGE (In years last birthday)<br><u>74</u> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED ACCOUNTANT</u>                                     |   |
| 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>MISSOURI</u>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 13. FATHER'S NAME<br><u>MICHAEL</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                      |   |
| 16. SOCIAL SECURITY NO<br><u>083-05-4463</u>  |   | 17. INFORMANT<br><u>CORA M. MARKS</u> Address <u>1301 15th St. N.W.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO<br>(c) _____   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Arteriosclerosis (Heart Disease), Cardiac Insufficiency</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>10-30-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-29-58</u> , 12____, and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>915 19th St NW Washington DC</u> <u>10-30-58</u> |   |   |   |
| ACTUAL SIGNATURE <u>Lewis H. Biben</u> M.D.   |   |   |   |
| PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN MD</u>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>CREMATION</u>   | 22b. DATE THEREOF<br><u>11-1-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>SUITLAND MARYLAND</u>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph Charles Siro</u>  |   | ADDRESS<br><u>1756 Penn. Av. NW</u>   | 24a. REC'D BY REGISTRAR<br><u>NOV 3 '58</u>   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Evans</u>  |   |   |   |



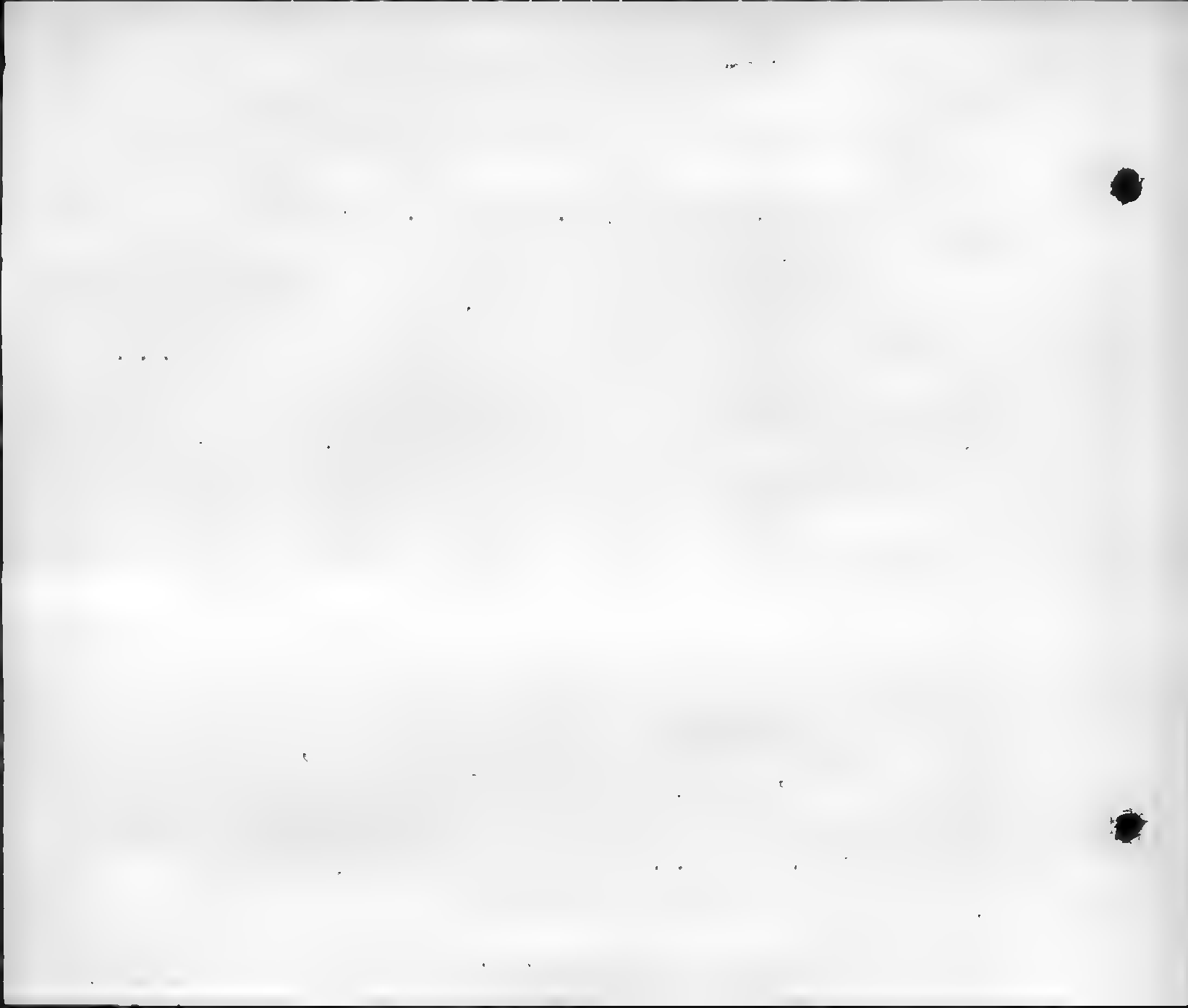
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11538 CERTIFICATE OF DEATH

Reg. Dist. No. 11518

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>21 days</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arlington</b> 82 X - 2                             |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |   | d. STREET ADDRESS<br><b>650 N. Jackson Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Juanita</b> Middle <b>May</b> Last <b>Martin</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>2</b> Year <b>1958</b>  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 27, 1897</b>   |  | 9. AGE (In years last birthday)<br><b>61</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>           |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                  |   | 13. FATHER'S NAME<br><b>William Harrison</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Nannie Vaughn</b>  |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                    |  |   |
| 16. SOCIAL SECURITY NO<br><b>None</b>   |                                  |   | 17. INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>                                      |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PERFORATED DIVERTICULUM OF COLIC</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>72</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE MYELOMA, HEMIA</b>  |                                  |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town)   |                                  | 20g. (County)   |   | 20h. (State)   |   |
| 21. I certify that I attended the deceased from <b>September 11, 1958</b> to <b>October 2, 1958</b> , that I last saw the deceased alive on <b>October 2, 1958</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.  |                                  |   |   |  |   |
| ACTUAL SIGNATURE <b>JAMES M. MARSH, M.D.</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b>   |   | DATE SIGNED<br><b>10/2/58</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>JAMES M. MARSH, M.D.</b>  |                                  | ADDRESS<br><b>National Institutes of Health<br/>Bethesda 14, Maryland</b>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>10/6/58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>COLUMBIA GARDENS CEMETERY</b> |   |
| 22d. LOCATION (City, town, or county)<br><b>ARLINGTON, VIRGINIA</b>   |                                  | 22e. (State)<br><b>ARLINGTON, VIRGINIA</b>  |   | 22f. (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>MARTIN W. HYSOING COMPANY</b>  |                                  | ADDRESS<br><b>1300 N. STREET, N.W.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>OCT 6 '58</b>                            |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                  | 24c. (State)  |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

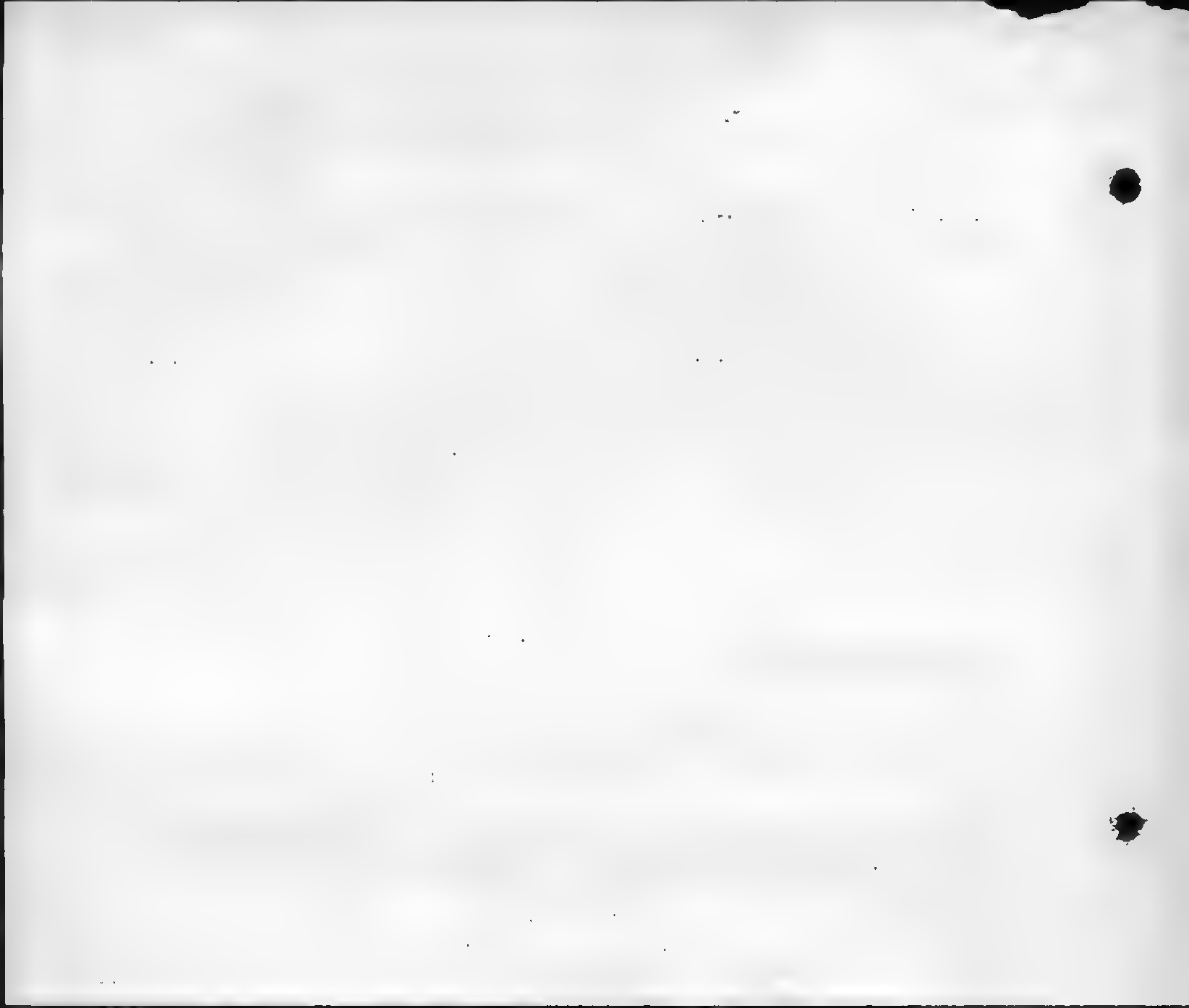
## 11539

## CERTIFICATE OF DEATH

## 11519

Reg. Dist. No. 215

|   |                                  |   |  |  |   |  |  |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>21 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital, NNM</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>F.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>d. STREET ADDRESS<br><b>RFD #1, Box 272</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Andrew Francis MAY</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 9 1958</b>  |  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-4-85</b>   | 9. AGE (In years last birthday)<br><b>72</b> yrs   | IF UNDER 1 YEAR<br>Months Days Hours Min  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mariner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |   | 13. FATHER'S NAME<br><b>Peter MAY</b>  |  |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Annie COLLINS</b>  |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes WWI - WWII</b> |  |   |  |  |
| 16. SOCIAL SECURITY NO<br><b>212-14-3948</b>  |                                  |   | 17. INFORMANT<br><b>(Wife) Mrs. Henrietta May, same as #2 above</b>  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial infarction</b><br>DUE TO<br>(c) <b>Acute gastrointestinal hemorrhage, cause undetermined.</b> |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>3 weeks</b><br><b>4 weeks</b> |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(Myocardial)</b><br><b>Arteriosclerotic Heart Disease with several previous infarctions (cardial)</b>  |                                  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>(City or town)</b> (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <b>September 19, 1958</b> , to <b>October 9, 1958</b> , that I last saw the deceased alive on <b>October 9, 1958</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.   |                                  |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><i>F. S. Caldwell</i>   |                                  | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital, NNM</b>   |  | DATE SIGNED<br><b>10-9-58</b>  |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>F. S. CALDWELL LT MB USN</b>  |                                  | Bethesda 14, Maryland   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-13-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   |  |  |
| 22d. LOCATION (City, town, or county)<br><b>Arlington</b>   |                                  | (State)<br><b>Virginia</b>  |  | 24a. REC'D BY REGISTRAR<br><b>10 OCT 14 '58</b>  |   |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>John M. Taylor &amp; Sons</i>  |                                  | 24c. REGISTRAR'S SIGNATURE<br><i>John M. Taylor &amp; Sons</i>  |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

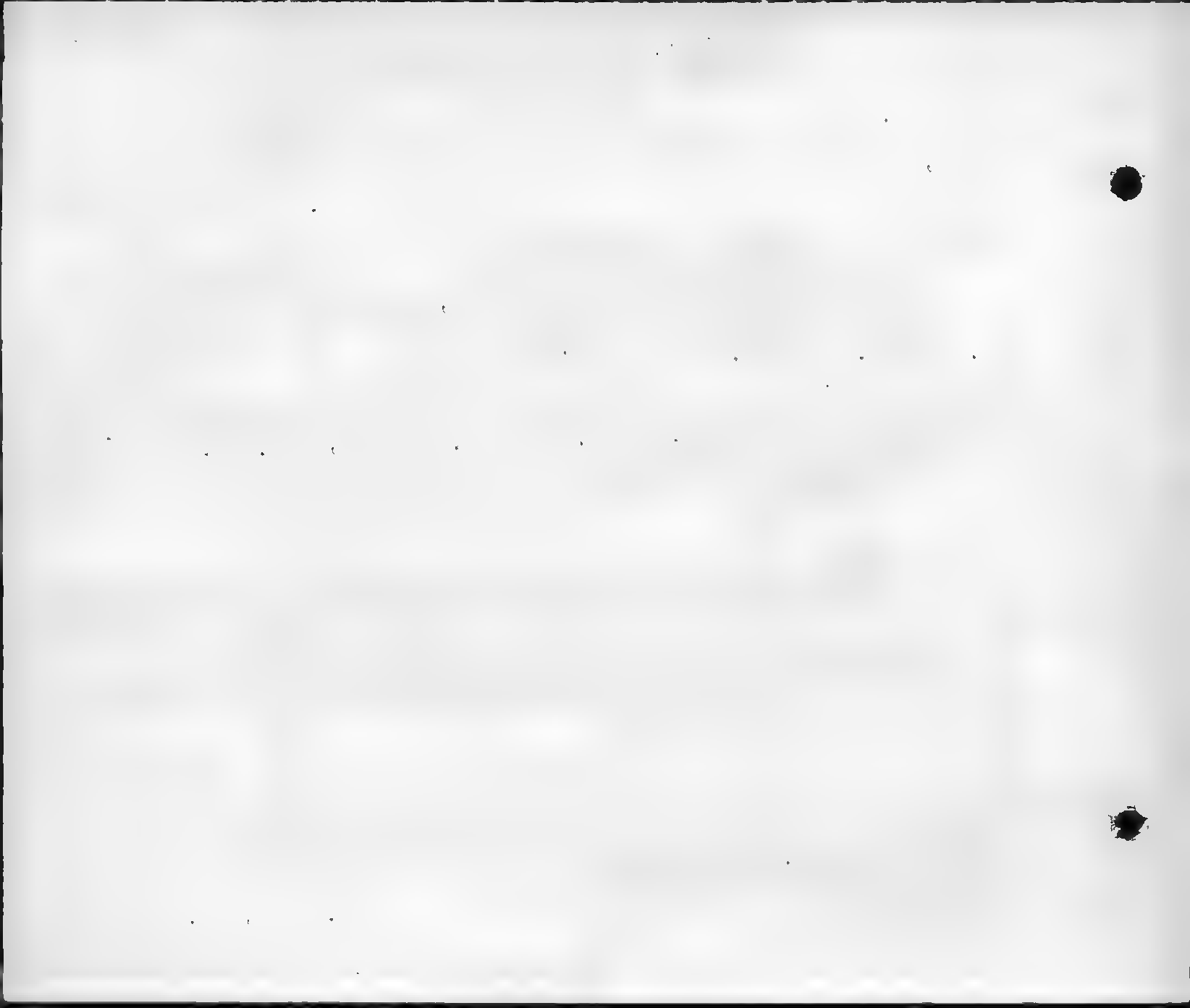
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11540 CERTIFICATE OF DEATH

11520

Reg. Dist. No.

|  |                              |   |  |   |   |   |   |
|--|------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont.</u> MARYLAND   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Washington</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>   |                              |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington, DC</u>                               |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Severely Sanitarium</u>   |                              |   |  | d. STREET ADDRESS<br><u>4107 Fordham Rd.</u>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Jeremiah William McCarty</u>  |                              |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>10/23 19 58</u>  |   |   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 30, 1891</u> | 9. AGE (In years last birthday)<br><u>67</u> yn   | IF UNDER 1 YEAR<br>Months Days<br><u>3 23</u> |   | IF UNDER 24 HRS<br>Hours Min<br><u>72</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. V/Pres. &amp; Treas. Chestnut Farms</u>   |                              |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dairy</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Illinois</u>          |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                              |   |  |   |   |   |   |
| 13. FATHER'S NAME<br><u>JAMES McCARTY</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY BUSEY</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES WW I</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>577-03-6607</u>   |  | 17. INFORMANT<br><u>Ruth B. McCarty, Wash. DC.</u>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>490X pulmonary congestion</u><br>DUE TO (b) <u>pneumonia bilat.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 arteriosclerosis; 2 left hemiplegia; 3 gouty arthritis.</u> |                              |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>72 hrs</u><br><u>72 hrs</u>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                  |   |
| 21. I certify that I attended the deceased from <u>July 1958</u> , to <u>23 Oct 1958</u> , that I last saw the deceased alive on <u>22 Oct 1958</u> , and that death occurred at <u>7:31 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd. Bethesda 14, Maryland</u> DATE SIGNED <u>23 Oct 58</u>   |                              |   |  |   |   |   |   |
| ACTUAL SIGNATURE <u>John M. Nyman</u> M.D.   |                              |   |  | PHYSICIAN'S NAME (Type) <u>JOHN M. NYMAN</u>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 22b. DATE THEREOF<br><u>10/27/1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Ft. Myer, Va.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph Sawicki, 1756 Pa. Ave. N.W.</u>  |                              |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 27 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>William E. Kraus</u>                 |   |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11450

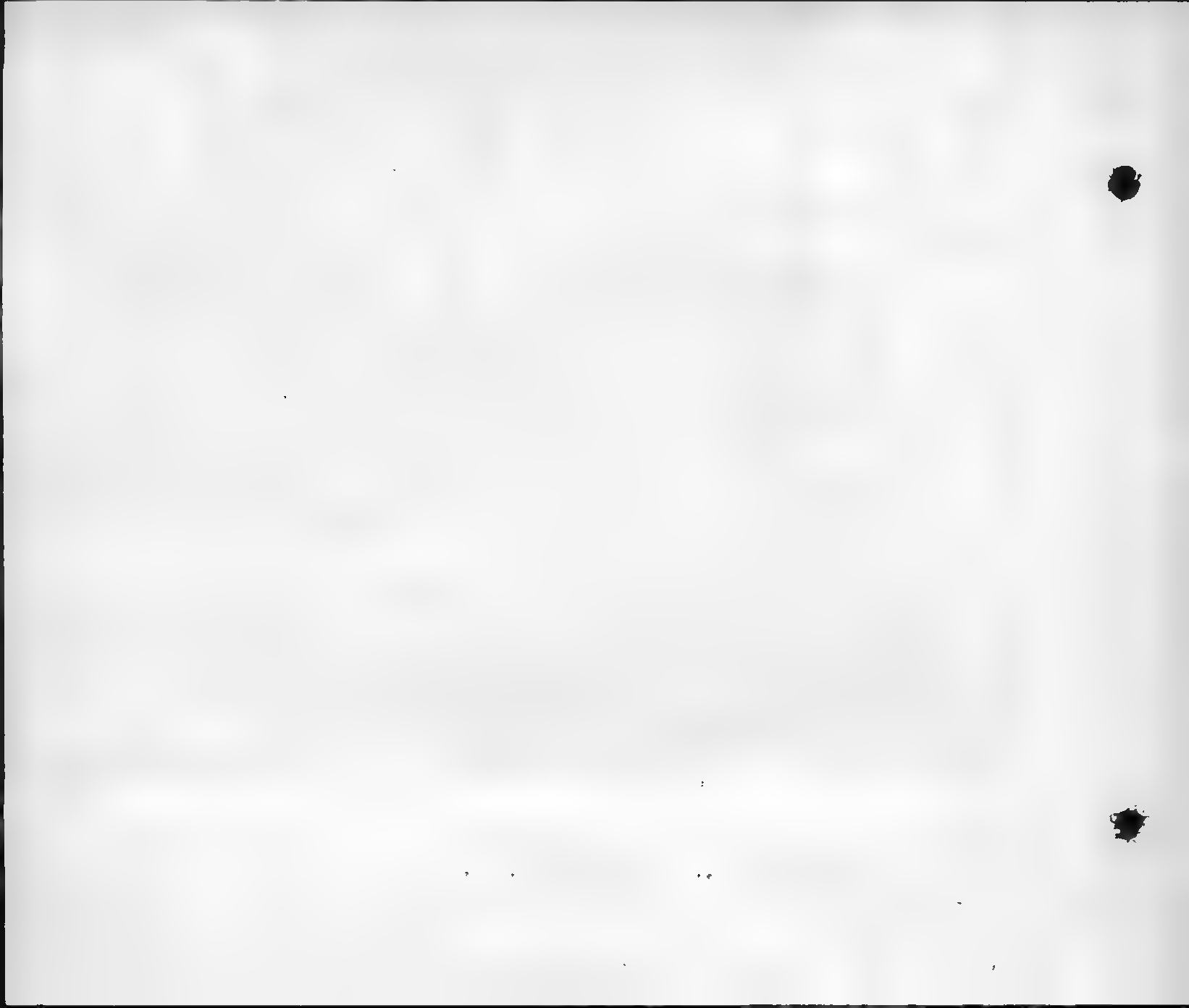
## CERTIFICATE OF DEATH

11521

Reg. Dist. No.

|   |                                  |   |                                   |  |                           |  |                          |
|---|----------------------------------|---|-----------------------------------|--|---------------------------|--|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i>   |                                  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><i>D.C.</i><br>b. COUNTY |                           |  |                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Takoma Park</i>  |                                  |   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Washington</i>                        |                           |  |                          |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><i>Washington Sen. &amp; Hosp.</i>   |                                  |   |                                   | d. STREET ADDRESS<br><i>7701 Georgia Ave. N.W.</i>   |                           |  |                          |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Annie</i> Middle <i>Robert</i> Last <i>M. C. Hughes</i>   |                                  |   |                                   | 4. DATE OF DEATH<br>Month <i>10</i> Day <i>21</i> Year <i>1958</i>   |                           |  |                          |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>7-4-74</i> | 9. AGE (In years last birthday)<br><i>84</i> yrs   | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS<br>Days  | IF UNDER 24 HRS<br>Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  |   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>   |                           | 11. BIRTHPLACE (State or foreign country)<br><i>Pa.</i>                |                          |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |                                  |   |                                   | 13. FATHER'S NAME<br><i>Harold Sheffy</i>  |                           |  |                          |
| 14. MOTHER'S MAIDEN NAME<br><i>Ellen Robert</i>   |                                  |   |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>None</i>  |                           |  |                          |
| 16. SOCIAL SECURITY NO.<br><i>None</i>  |                                  |   |                                   | 17. INFORMANT<br><i>Daughter</i>   |                           |  |                          |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral emboli</i><br><i>332x</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>332x</i> |                                  |   |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 months</i><br><i>5 year</i>   |                           |  |                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                 |                           |  |                          |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  |                                  |   |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work                    |                           |  |                          |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  |   |                                   | 20f. (City or town) (County) (State)   |                           |  |                          |
| 21. I certify that I attended the deceased from <i>4-3</i> 19 <i>46</i> , to <i>10-21</i> 19 <i>58</i> , that I lost saw the deceased alive on <i>10-21</i> 19 <i>58</i> , and that death occurred at <i>1:50 P.M.</i> , from the causes and on the date stated above   |                                  |   |                                   |  |                           |  |                          |
| ACTUAL SIGNATURE <i>W. B. Warding MD</i>  |                                  |   |                                   | ADDRESS (Street, city or town, state) <i>837 Bonifant St. Silver Spring Md.</i>  |                           |  |                          |
| DATE SIGNED <i>10/21/58</i>   |                                  |   |                                   | PHYSICIAN'S NAME (Type) <i>837 Bonifant St. Silver Spring, Md.</i>   |                           |  |                          |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF<br><i>10-24-58</i>  |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><i>EVERGREEN CEM</i>   |                           | 22d. LOCATION (City, town, or county) (State)<br><i>GETTYSBURG PA.</i> |                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Dean Funeral Home</i>  |                                  |   |                                   | ADDRESS<br><i>4812 Ga. Ave. N.W.</i>   |                           |  |                          |
| 24a. REC'D BY REGISTRAR<br><i>OCT 29 1958</i>   |                                  |   |                                   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Evans</i>   |                           |  |                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11541

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>St. Philomena Nursing Home</b>   |   | d. STREET ADDRESS<br><b>4601 Hallet Pl.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>McDermott</b> Last <b>McDermott</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>14,</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 16, 1880</b>                                   |
| 9. AGE (In years last birthday) <b>78</b> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>7</b> Days <b>14</b> Hours <b>19</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>James O'Horo</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Nellie McLane</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Robert McDermott</b>  |   | Address<br><b>1812 "K" St.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>Approx 20 yrs.</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <b>9-6-57</b> to <b>10-14-58</b> , that I last saw the deceased alive on <b>10-11-58</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE <b>Harry J. Kicheter</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>2205 Richland St. Silver Spring, Md.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>H. J. Kicheter, M.D.</b>   |   | DATE SIGNED <b>Silver Spring, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/17/58</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Silver Spring, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Hewlett Sons</b>  |   | ADDRESS<br><b>1756 Penna. Av.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>OCT 16 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>   |  |



11542  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>X Bethesda</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5119 Bradley Blvd.</b>  |                                     | d. STREET ADDRESS<br><b>5119 Bradley Blvd.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Hilda Emily McKay</b>  |                                     | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>6</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/8/1899</b>  |
| 9. AGE (in years last birthday)<br><b>59</b> yrs   |                                     | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>28</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Canada</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John Scheifle</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Emily Sippel</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO<br><b>None</b>   |  |
| 17. INFORMANT<br><b>E.A. McKay (husband)</b>   |                                     | 18. ADDRESS<br><b>Same as Item 2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                     |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b>  |                                     |   |  |
| DUE TO (b) <b>Carbon-monoxide Poisoning</b>  |                                     |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>-----</b>  |                                     |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>   |                                     |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Found dead in auto at home with hose attached to exhaust</b>  |                                     |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                     | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                     | 20e. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |                                     |   |  |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>   |                                     | DATE SIGNED <b>10/6/58</b>  |  |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>   |                                     | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|  |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL CREMATION REMOVAL (Specify)<br><b>Cremation</b>  | 22b. DATE THEREOF<br><b>10/8/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |                                     | ADDRESS<br><b>Bethesda, Maryland</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>OCT 8 58</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Frank</b>   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11524

11543

14. See: Birth Cert. et

Reg. Dist No.

|  |  |   |  |   |  |  |  |  |  |   |  |   |  |   |  |                                      |  |   |  |  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|---|--|--------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b>  |  | b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>BETHESDA</b>  |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A</b>   |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>MONTGOMERY</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CABIN JOHN</b> |  | d. STREET ADDRESS<br><b>8 Carver Rd</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                      |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>KEITH ANTONIO MC KINNEY</b>   |  | 4. DATE OF DEATH<br><b>OCTOBER 19 1958</b>  |  | 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>COLORED</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10-3-58</b>  |  | 9. AGE (In years last birthday)<br><b>15</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.                       |  |                                      |  |   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BETHESDA MD.</b>                                  |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME<br><b>FRANK D. MC KINNEY</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Frankie Mae WILLIAMS</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>father -</b>                     |  | 16. SOCIAL SECURITY NO.   |  |                                      |  |   |  |  |  |
| 17. INFORMANT<br><b>Sten -</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>475X</b> DUE TO <b>Cephalosporin</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>upper Respiratory Infection</b> DUE TO (c) <b>Intestinal Colic</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>10:35 AM</b><br>e. m. p. m.                        |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  | 20f. (City or town) (County) (State) |  |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |  |  |   |  |   |  |   |  |                                      |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Frank J. Broschant</b>  |  | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DATE SIGNED<br><b>10-19-58</b>  |  | EXAMINER'S NAME (Type)<br><b>FRANK J. Broschant</b>   |  | 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>10-21-58</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN</b> |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Ernest James Co. Wash. D.C.</b>  |  | ADDRESS<br><b>1432 4th St</b>   |  | 24a. REC'D BY REGISTRAR<br><b>ACT 21 '58</b>  |  | DATE   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Wm J. Frank</b>   |  | 24c. DATE   |  | 24d. SIGNATURE  |  | 24e. DATE   |  |                                      |  |   |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11451

## CERTIFICATE OF DEATH

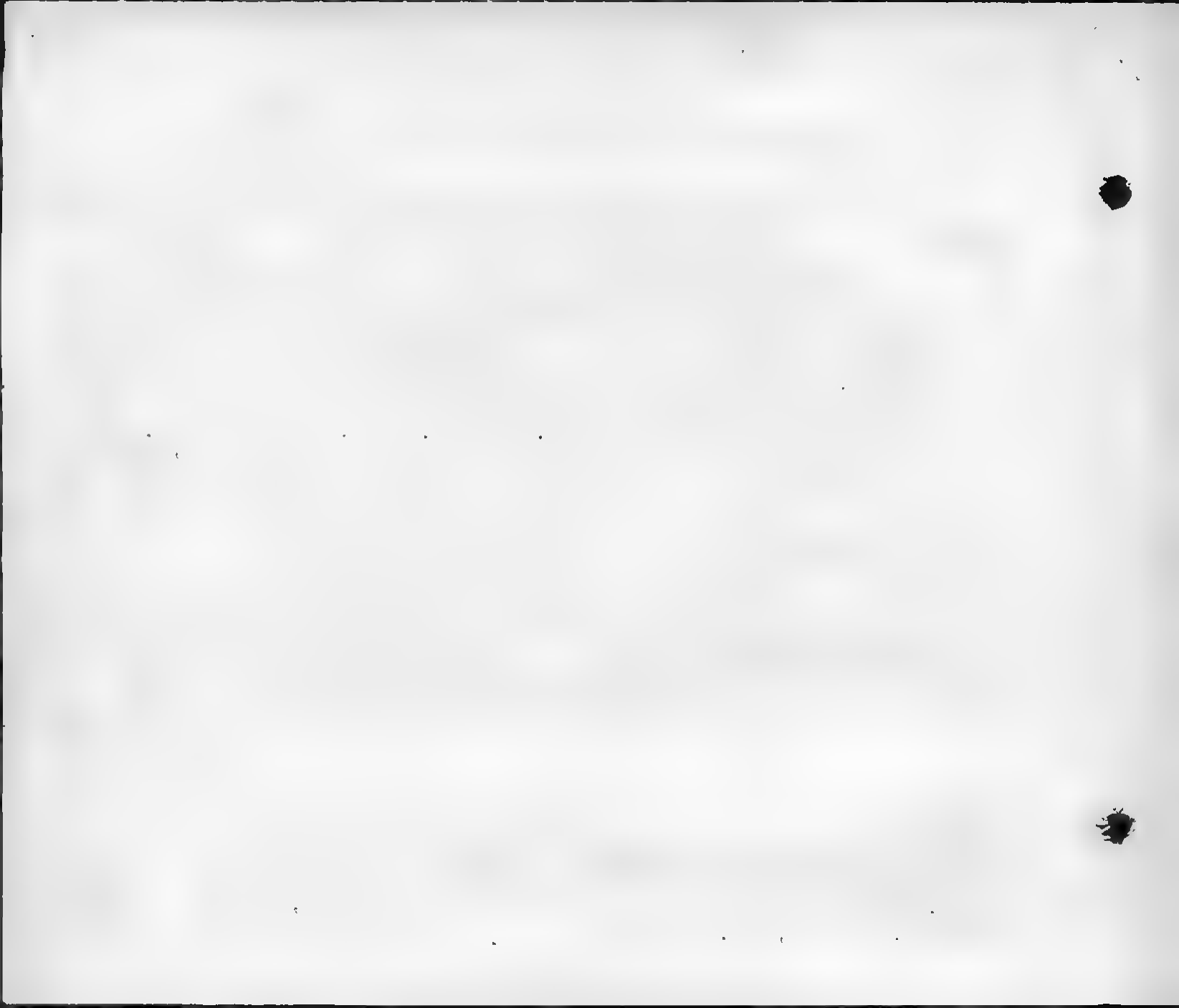
Reg. Dist. No.

11525

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>3 weeks</u>  |  |  |  | d. STREET ADDRESS <u>1616 Oaklawn Ct.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>FOSTER</u> Last <u>Mears</u>  |  |  |  | 4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1958</u>   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>Cauc.</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5/19/82</u>  |  |
| 9. AGE (In years last birthday) <u>76</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>                              |  |
| 13. FATHER'S NAME <u>Samuel Lawrence Foster</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Marion Upham</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <u>Mr. Samuel F. Mears, 1616 Oaklawn Ct. Silver Spring, Maryland</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>   |  |  |  |  |  |  |  |
| DUE TO (b) <u>Generalized Atherosclerosis</u>   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary occlusion -</u>  |  |  |  |  |  |  | <u>20 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Moderately severe Hypertension - years</u>   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                     |  |
|   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>Oct 6, 1958</u> , to <u>Oct 26, 1958</u> , that I last saw the deceased alive on <u>Oct 26, 1958</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| ADDRESS (Street, city or town, state)   |  |  |  | DATE SIGNED  |  |  |  |
| ACTUAL SIGNATURE <u>Wilford P. Meyers</u> M.D.  |  |  |  | <u>Oct 26, 1958</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Wilford P. Meyers MD.</u>  |  |  |  | <u>8323 Haddon Drive TR, PK, Md.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                      |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)  |  |
| <u>TRANS. &amp; BURIAL</u>  |  | <u>10/29/58</u>                        |  | <u>CEDAR GROVE CEMETERY</u>  |  | <u>NORFOLK, VIRGINIA</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>  |  |  |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE   |  |
| <u>Raymond H. Gaska</u>   |  |  |  | DATE <u>OCT 28 '58</u>   |  | <u>Arthur S. Grant</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11544

## CERTIFICATE OF DEATH

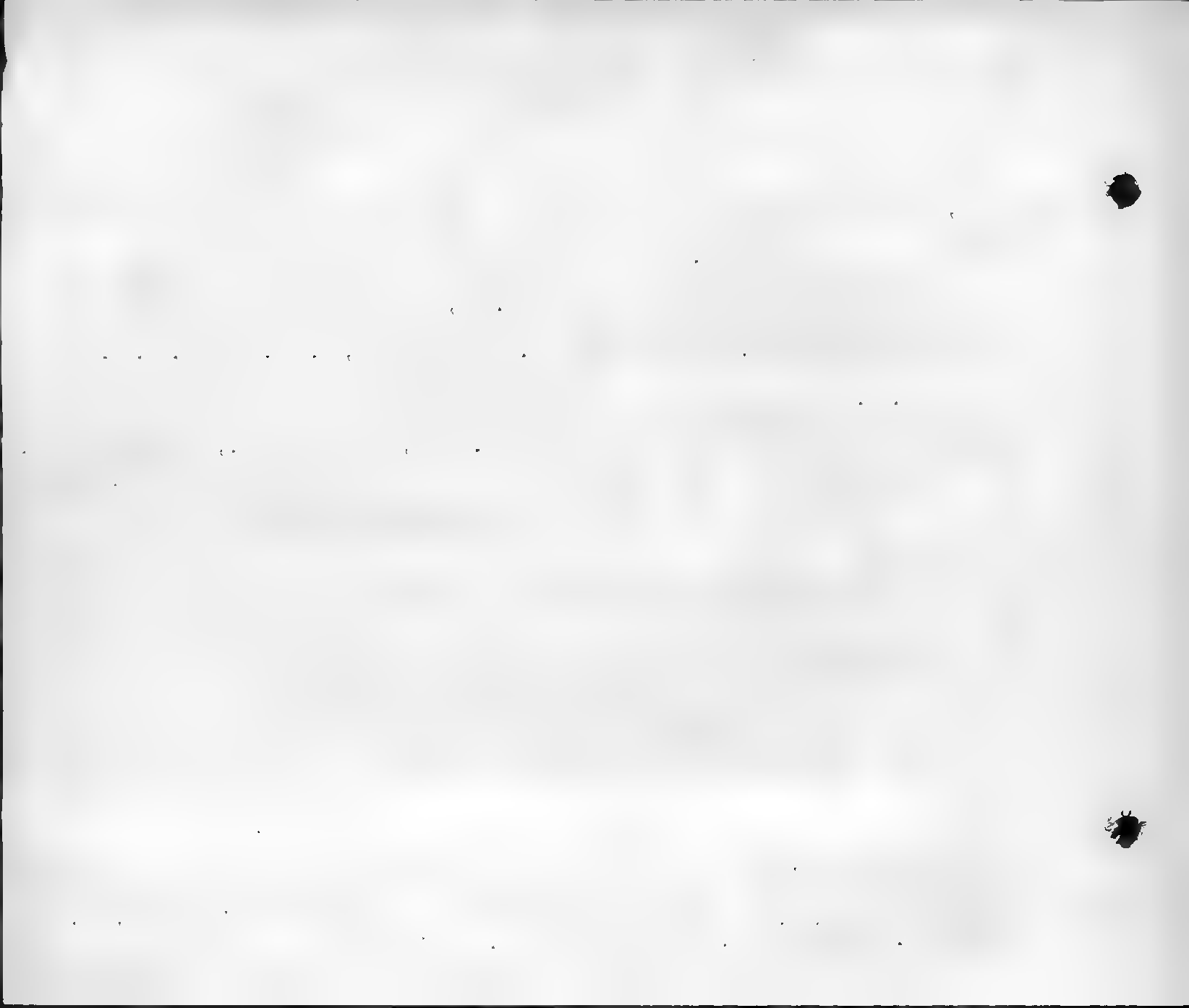
## 11526

Reg. Dist. No.

|   |                                  |   |  |  |  |   |  |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>                                     |  |   |  |
| c. LENGTH OF STAY IN 1b<br><u>2 years</u>   |                                  |   |  | d. STREET ADDRESS<br><u>11503 Higby St</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>11,503 Higby Street</u>  |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Enid M. Mews</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>21</u> Year <u>1958</u>  |  |   |  |
| 5 SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Jan. 16, 1908</u>   |  | 9. AGE (In years last birthday) <u>50</u> yrs.                                      |  |
|   |                                  |   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
|   |                                  |   |  | Months   |  | Days  |  |
|   |                                  |   |  | Hours  |  | Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Statistical Clerk Dept. Agriculture USGovt.</u>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Huntersville, W. Va.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                     |  |
| 13. FATHER'S NAME<br><u>Joseph S. B. Pyles</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Ann Virginia Church</u>  |  |   |  |
| 15. WAS DECEASED SEVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |   |  |
|   |                                  |   |  | 17. INFORMANT<br><u>Lewis L. Mews, 11503 Higby St., Silver Spring, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Melanotic Sarcoma metastases</u><br>2X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Melanotic Sarcoma left chest &amp; thyroid gland</u><br>DUE TO<br>(c) <u>5 1/2 yrs</u>       |                                  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.  |                                  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work                                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
|   |                                  |   |  | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>20 July</u> , 19 <u>58</u> , to <u>21 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Oct</u> , 19 <u>58</u> , and that death occurred at <u>1:00</u> A. M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>11137 George Ave Wd</u> DATE SIGNED <u>20 Oct 58</u> |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Mertie T. White</u> M.D.  |                                  |   |  | PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 22b. DATE THEREOF<br><u>OCT. 23, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>FORT LINCOLN CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>PRINCE GEORGE'S COUNTY, MD.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond C. Galt</u>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 23 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                                |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11545

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                              |   |                                       |   |   |  |  |
|---|------------------------------|---|---------------------------------------|---|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>MONTGOMERY</b><br>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c LENGTH OF STAY IN 1b <b>4 days</b><br>d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>   |                              |   |                                       | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a STATE <b>District of Columbia</b><br>b COUNTY<br>c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b><br>d. STREET ADDRESS <b>1114 Sumner Rd., S. E.</b><br>e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Oscar</b> Middle <b>Lynford</b> Last <b>Millard</b>  |                              | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>28</b> Year <b>1958</b>  |                                       |   |   |  |  |
| 5 SEX <b>Male</b>   | 6 COLOR OR RACE <b>Negro</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <b>March 26, 1904</b> | 9. AGE (In years last birthday) <b>54 yrs</b>   | IF UNDER 1 YEAR: Months <b>54</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Animal Caretaker</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY <b>Health Research</b>  |                                       | 11 BIRTHPLACE (State or foreign country) <b>District of Columbia</b>  |   |  |  |
| 13 FATHER'S NAME <b>Robert Millard</b>  |                              | 14. MOTHER'S MAIDEN NAME <b>Rosa Brooks</b>   |                                       |   |   |  |  |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) <b>No</b>   |                              | 16 SOCIAL SECURITY NO. <b>579-05-2737</b>   |                                       | 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>   |   |  |  |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage Rt Cerebellar hemisphere</b><br>DUE TO (b) <b>Diabetes mellitus &amp; Cerebral Arteriosclerosis</b><br>DUE TO (c) <b>30 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |                              |   |                                       |   | INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>                              |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |   |                                       |   |   |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                       |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <b>October 24</b> , 19 <b>58</b> , to <b>October 28</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>October 28</b> , 19 <b>58</b> , and that death occurred at <b>3:58 AM</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>10/28/58</b><br>ACTUAL SIGNATURE <b>Arnold N. Weinberg</b> M.D. <b>The National Institutes of Health</b><br>PHYSICIAN'S NAME (Type) <b>Arnold N. Weinberg, M. D.</b> <b>Bethesda 14, Maryland</b> |                              |   |                                       |   |   |  |  |
| 22a BURIAL, CREMATION, REMOVAL (Specify) <b>Oct 28/58</b>   |                              | 22b. DATE THEREOF <b>Oct 28/58</b>  |                                       | 22c. NAME OF CEMETERY OR CREMATORY <b>Shodalaon</b>   |   |  |  |
| 22d. LOCATION (City, town, or county) <b>Washington</b>   |                              | (State) <b>DC</b>   |                                       |   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Shaver E. Hunter</b>  |                              | ADDRESS <b>2512 S. Herberton Rd. S.E.</b>   |                                       | 24a. REC'D BY REGISTRAR <b>NOV 14 1958</b> DATE   |   |  |  |
| 24b REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>  |                              |   |                                       |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11546 CERTIFICATE OF DEATH

11527

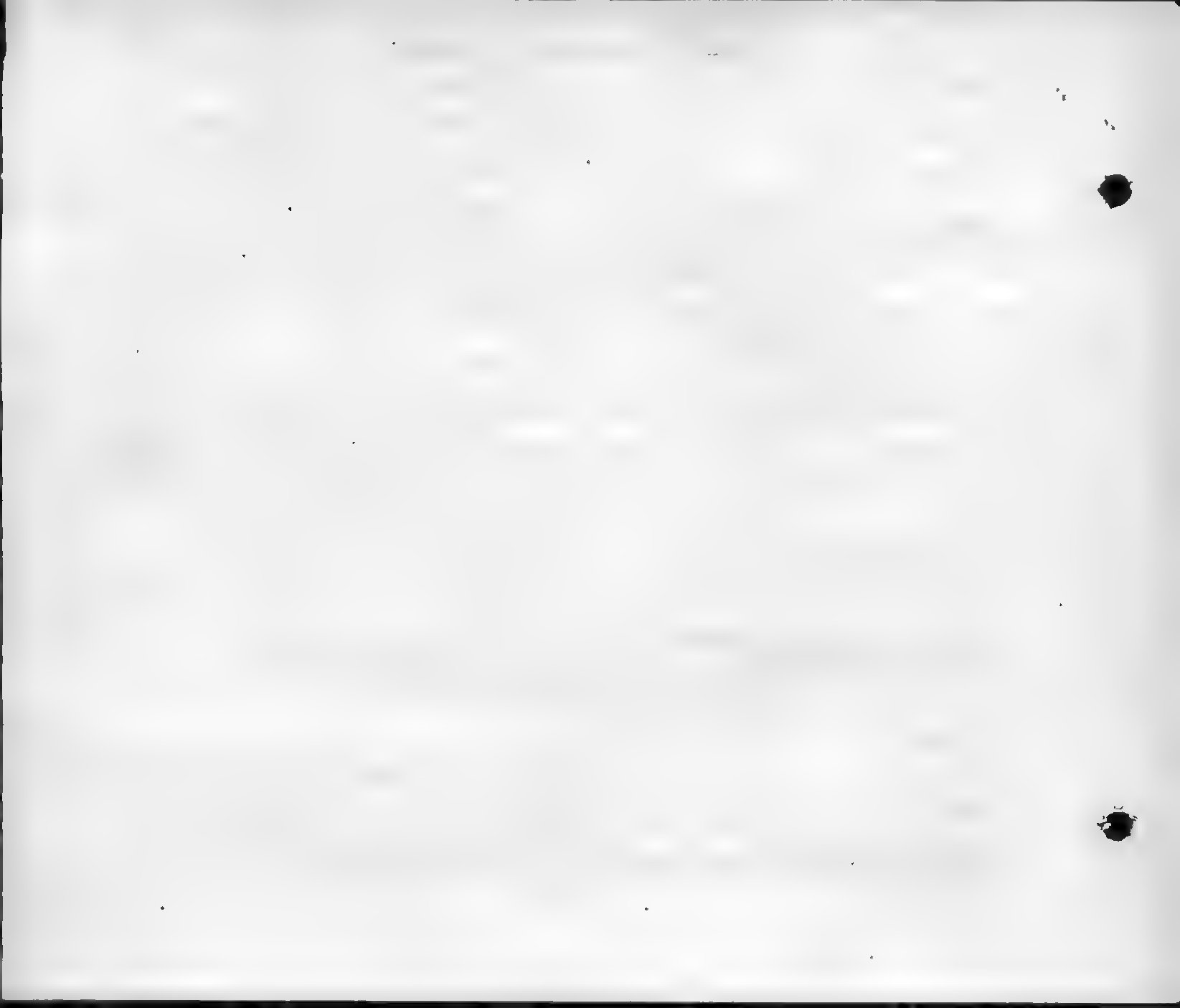
Reg. Dist. No.

|   |                               |  |   |   |   |  |  |
|---|-------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>  |                               |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>   |   |  |  |
| c. LENGTH OF STAY IN 1b <b>2 hrs.</b>   |                               |  |   | d. STREET ADDRESS <b>4312 Fern Hill Rd.</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>  |                               |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>STANLEY</b> Middle <b>RANDOLPH</b> Last <b>MILLER</b>  |                               |  |   | 4. DATE OF DEATH Month <b>OCT.</b> Day <b>5</b> Year <b>1958</b>  |   |  |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>3/7/22</b>                                  | 9. AGE (In years last birthday) <b>36 yrs.</b>  | IF UNDER 1 YEAR Months <b>6</b> Days <b>28</b> Hours <b></b> M n. | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>   |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>VAN MORT BRAKE SERVICE</b> |   | 11. BIRTHPLACE (State or foreign country) <b>NORFOLK VIRGINIA</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>CHARLES MILLER</b>   |                               |  |   | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO <b>Yes-Unknown</b>  |   | 17. INFORMANT <b>STEP DAUGHTER - Shirley Shaver</b>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fat Embolism</b><br><b>581.0</b> DUE TO <b>Fatty Metamorphosis of liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unknown</b><br>DUE TO (c) <b>Unknown</b>      |                               |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>                                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |                               |  |   |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |  |  |
| 20c. TIME OF INJURY Month. Day. Year <b>19</b><br>Hour a. m. p. m.  |                               |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |  |
|   |                               |  |   | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that I attended the deceased from <b>Oct 3, 1958</b> , to <b>Oct 5, 1958</b> , that I last saw the deceased alive on <b>Oct 5, 1958</b> , and that death occurred at <b>9:57 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>927 Peaching Dr., Silver Spring, Md.</b> DATE SIGNED <b>Oct 5, 58</b> |                               |  |   |   |   |  |  |
| ACTUAL SIGNATURE <b>Samuel S. Kimble</b>  |                               |  |   | M.D. <b>927 Peaching Dr., Silver Spring, Md.</b>  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>S. T. KIMBLE</b>   |                               |  |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>10/7/58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>   |   | 22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>  |                               |  |   | 24a. REC'D BY REGISTRAR <b>DATE OCT 7 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE <b>C. T. ...</b>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. BROSBART NOTED (DEF)





## 11547 CERTIFICATE OF DEATH

11528

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>   |  | d. STREET ADDRESS <u>7312 Maple Avenue</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Emily Chamberlin Moore</u>  |  | 4. DATE OF DEATH Month Day Year <u>10 - 15 - 1958</u>  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 28 1969</u>                                    |
| 9. AGE (In years last birthday) <u>89</u> yrs.  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Russell T Chamberlin</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Harriett Clayton</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO <u>None</u>   |   |
| 17. INFORMANT <u>Ruth Moore Camp-Dougherty</u>  |  | Address <u>Same</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u><br>DUE TO (b) <u>Artificial Dislocation of Hip</u><br>DUE TO (c) <u>Cerebral Infarction Right Frontal Lobe</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u><br><u>24 hours</u><br><u>?</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I attended the deceased from <u>1948</u> to <u>Oct 15</u> 1958, that I last saw the deceased alive on <u>Oct 15</u> 1958, and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE <u>Stewart Clapp</u>   |  | ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW Wash D.C.</u>  |   |
| DATE SIGNED <u>10/17/58</u>   |  |  |   |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  | 22b. DATE THEREOF <u>10/18/58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>  |  | ADDRESS <u>Bethesda, Maryland</u>  |   |
| 24a. REC'D BY REGISTRAR <u>DATE OCT 20 1958</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>James S. Knaus</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11548

## CERTIFICATE OF DEATH

11529

Reg. Dist. No. 215

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1 PLACE OF DEATH<br>a COUNTY<br>Montgomery MARYLAND   |                               | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a STATE<br>Maryland<br>b COUNTY                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)  |                               | c. LENGTH OF STAY IN 1b<br>1 day  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. Naval Hospital  |                               | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Lexington Park  |   |
|   |                               | d. STREET ADDRESS<br>Spring Valley Trailer Park   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Donna Lee MURPHY  |                               | 4. DATE OF DEATH<br>Month Day Year<br>October 17 1958   |   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-15-58  |
| 9. AGE (In years last birthday)<br>yrs  |                               | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  | 11. IF UNDER 24 HRS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - -  |   |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                               | 12. CITIZEN OF WHAT COUNTRY<br>USA  |   |
| 13. FATHER'S NAME<br>Patrick Steven MURPHY  |                               | 14. MOTHER'S MAIDEN NAME<br>Nancy Lee BERNGEN   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |                               | 16. SOCIAL SECURITY NO.<br>None   |   |
| 17. INFORMANT<br>Official Navy Records  |                               | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 773.5 Pulmonary Hyaline Membrane Disease<br>DUE TO (b) Prematurity<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)                                    |                               | INTERVAL BETWEEN ONSET AND DEATH<br>33 hrs<br>33 hrs  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from October 16, 1959, to October 17, 1958, that I last saw the deceased alive on October 17, 1958, and that death occurred at 8:32 A.M. from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>J. C. PARKE, JR., LT, MC, USN Bethesda 14, Maryland 10-17-58 |                               |   |   |
| ACTUAL SIGNATURE<br>J. C. PARKE, JR.  |                               | M. D. U. S. Naval Hospital, NNMC  |   |
| PHYSICIAN'S NAME (Type)<br>J. C. PARKE, JR., LT, MC, USN  |                               | Bethesda 14, Maryland   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 22b. DATE THEREOF<br>10-22-58 | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  | 22d. LOCATION (City, town, or county) (State)<br>Arlington Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Adams Funeral Home, 4748 Wisc. Ave., NW, WashDC   |                               | 24a. REC'D BY REGISTRAR<br>DATE OCT 20 58   | 24b. REGISTRAR'S SIGNATURE<br>Arthur L. Evans                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11452

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>19 days</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>   |  |   |  | d. STREET ADDRESS <u>512 Ashford Rd.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Ruth Evelyn Neal</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>9</u> Year <u>1958</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5-7-07</u>  |  |
| 9. AGE (In years last birthday) <u>51</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>9</u> Hours <u>19</u> Min <u>58</u> |  | IF UNDER 24 HRS<br>Months <u>10</u> Days <u>9</u> Hours <u>19</u> Min <u>58</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>                               |  | 11. BIRTHPLACE (State or foreign country) <u>TOWA</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>America</u>   |  |
| 13. FATHER'S NAME <u>John M. Studeman</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Grace Browning</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no (or unknown) (If yes, give war or dates of service) <u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO <u>—</u>  |  | 17. INFORMANT <u>Hospital Records</u> Address <u>—</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>DUE TO (b) <u>Pulmonary Bilateral</u><br>DUE TO (c) <u>Metastatic Carcinoma</u><br>DUE TO (d) <u>Primary Adeno-Carcinoma</u><br>DUE TO (e) <u>Mediastinum</u><br>DUE TO (f) <u>left Breast</u> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mo</u><br><u>6 mo.</u><br><u>4 yrs</u>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |  |
| 20f. (City or town)  |  |   |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <u>Aug 16, 1954</u> to <u>Oct 9, 1958</u> that I last saw the deceased alive on <u>Oct 8, 1958</u> and that death occurred at <u>4:00 PM</u> from the causes and on the date stated above.   |  |   |  |  |  |   | DATE SIGNED <u>Oct 9, 1958</u>   |
| ACTUAL SIGNATURE <u>George L. Ball</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>7835 Eastern Ave Silver Spring Md</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>George L. Ball</u>  |  |   |  | DATE SIGNED <u>Oct 9, 1958</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>   |  | 22b. DATE THEREOF <u>10/11/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>SPRINGDALE CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>CLINTON, IOWA</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawch</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11531

Reg. Dist. No.

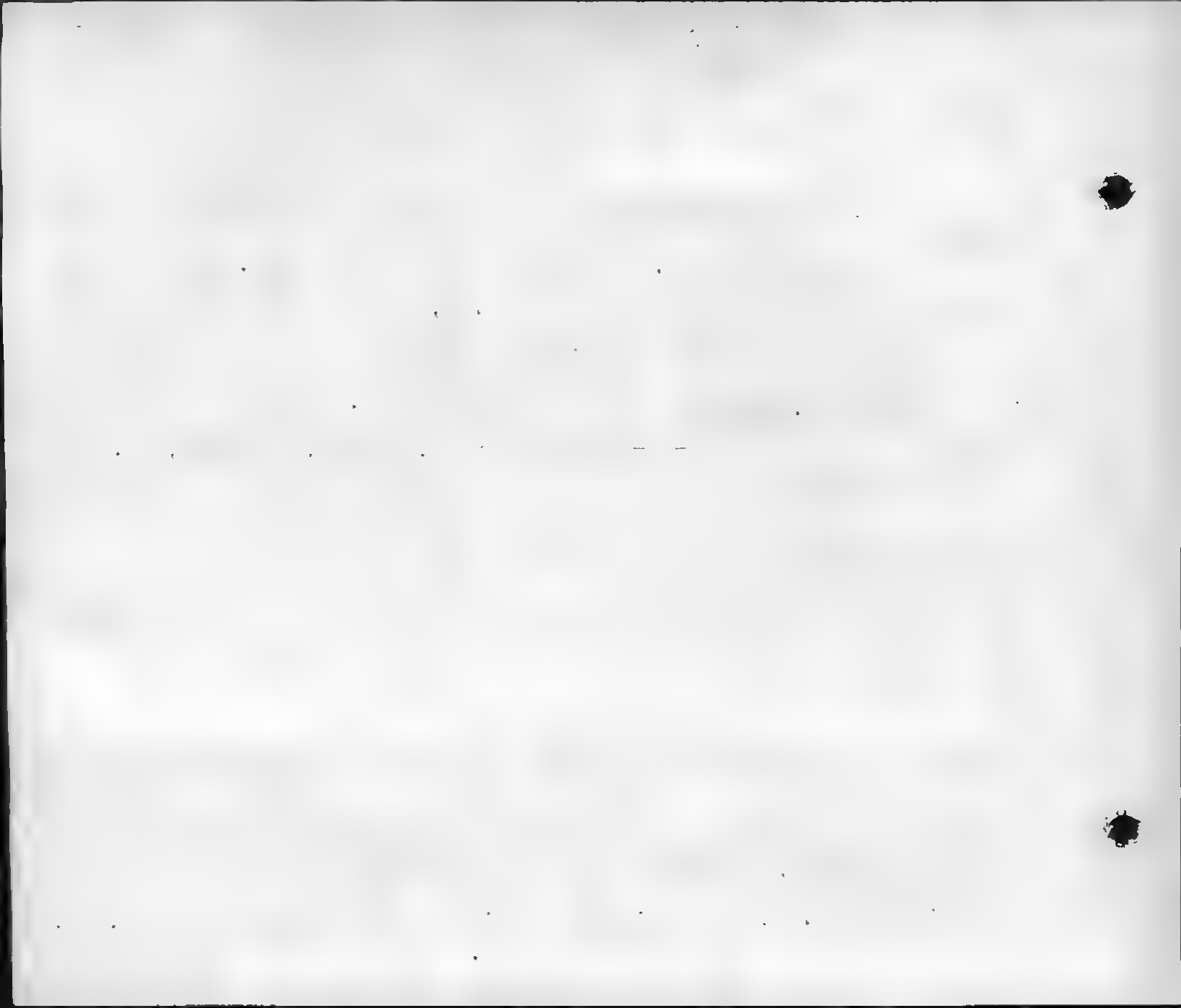
FOR STATE  
HEALTH DEPT.

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                               | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>              |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26224 Town Spring Road</b>   |                               | d. STREET ADDRESS <b>26224 Town Spring Road</b>  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Ralph W. Nealan</b>   |                               | 4. DATE OF DEATH <b>Oct. 11 1958</b>   |                                       |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Feb. 28, 1919</b> |
| 9. AGE (in years last birthday) <b>39 yrs</b>  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                       |
| 13. FATHER'S NAME <b>Charles R. Nealan</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Martha E. Hester</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>217-14-7468</b>   |                                       |
| 17. INFORMANT <b>Mrs Dora E. Nealan, Damascus, Md.</b>   |                               | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thoracic hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shot gun wound in left chest</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>   |                               |  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted shot gun wound</b>                         |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                       |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                       |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                       |
|  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                       |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Oct. 14, 1958</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Liberty Baptist</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Lisbon, Howard Co. Md.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Mylesworth</b>   |                               | ADDRESS <b>Damascus, Md.</b>   |                                       |
| 24a. REC'D BY REGISTRAR <b>OCT 14 '58</b>  |                               | DATE   |                                       |
| 24b. REGISTRAR'S SIGNATURE <b>W. J. L. Kline</b>   |                               |  |                                       |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

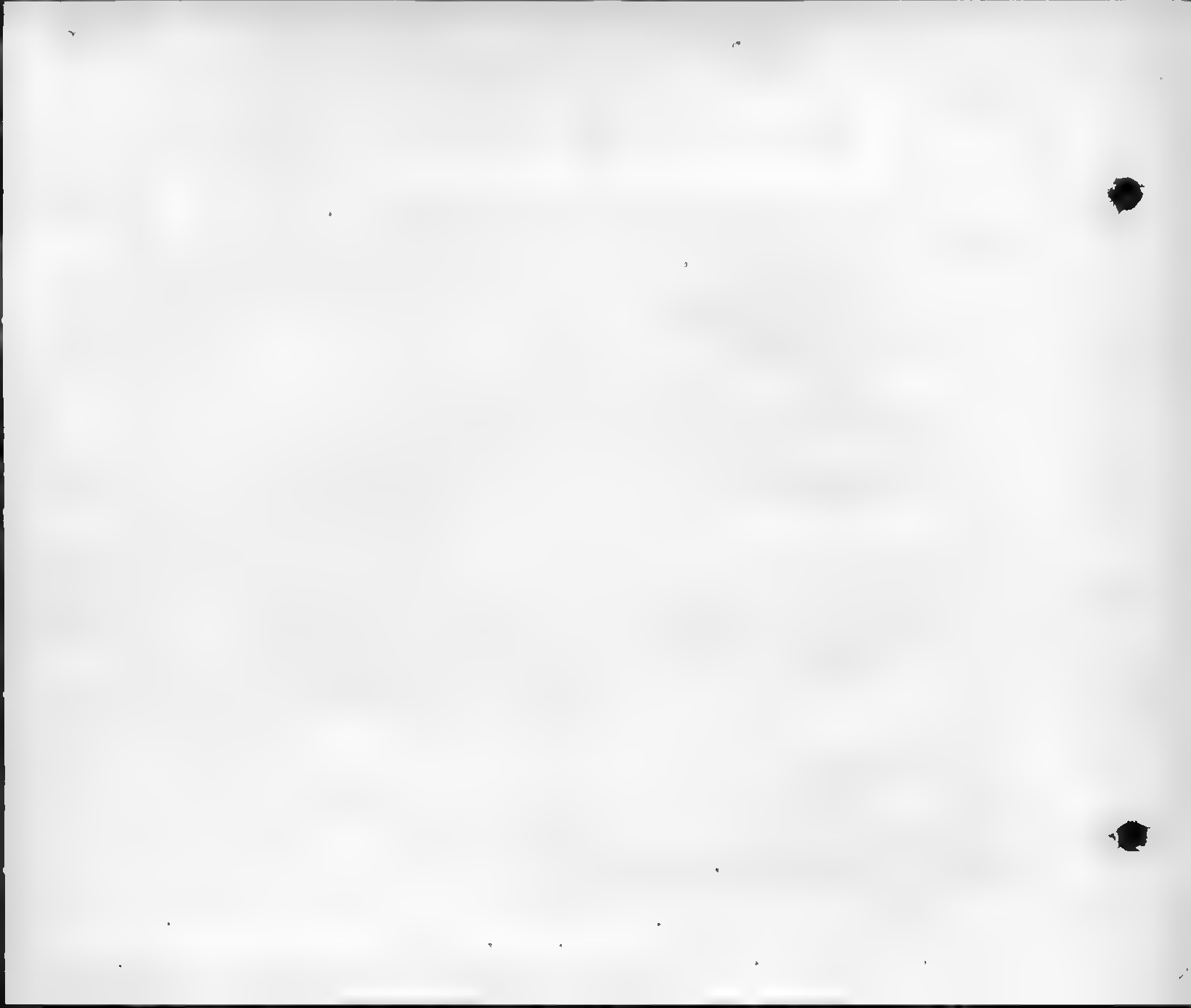
11532

11550

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Kensington</i>   |                                      | c. LENGTH OF STAY IN 1b<br><i>X</i> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Wheaton</i>                   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Kensington Gardens Nursing Home</i>  |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>William J. Nealon</i>   |                                      | 4. DATE OF DEATH <i>Oct 28 1958</i>  |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>W</i>            | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>11/16/74</i>                                      |
| 9. AGE (In years last birthday)<br><i>83</i> yrs  |                                      | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired Policeman</i>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Ireland</i>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Ireland</i>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Michael Nealon</i>  |                                      | 14. MOTHER'S MAIDEN NAME<br><i>Mary Mullen</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                      | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><i>Dorothy E. Blankenship same as #2</i>   |                                      | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Bladder</i><br>DUE TO <i>Carcinoma of Prostate</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i><br><i>5 years</i>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Infirmities of age</i>  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>1953</i> to <i>Date</i> , <i>1958</i> , that I last saw the deceased alive on <i>Oct 20 1958</i> , and that death occurred at <i>10:45 A.M.</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED         |                                      |  |  |
| ACTUAL SIGNATURE <i>G Roland Gable</i> M.D.   |                                      | DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type) <i>G. ROLAND GABLE</i>  |                                      | <i>900-17-St. N.W. - D.C.</i>  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><i>burial</i>   | 22b. DATE THEREOF<br><i>10/31/58</i> | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olivet Cemetery</i>   | 22d. LOCATION (City, town, or county) (State)<br><i>Washington, D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>The S.H. Hines Co.</i>   |                                      | 24a. REC'D BY REGISTRAR<br><i>DATE OCT 30 '58</i>  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hines</i>                     |



11551

## CERTIFICATE OF DEATH

11533

Reg. Dist. No.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Dist. of Columbia</b> b. COUNTY                        |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lethesda</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>8 hours</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>2900 Rittenhouse St. N.W.</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Paul Raymond Neff</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>October 24 19 58</b>  |  |   |   |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 29, 1898</b>  |   |
| 9. AGE (In years lost birthday)<br><b>63 yrs</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS.<br>Months Days Hours Min   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Patent Examiner</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |   |  |   |   |
| 13. FATHER'S NAME<br><b>Charles Joseph Neff</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Page</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br><b>Son—William James Neff—same</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b>  |  |  |  |   |  |   | <b>1 year</b>   |
| DUE TO (b) <b>Primary Amyloidosis</b>   |  |  |  |   |  |   | <b>18 mos</b>   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |   |   |
| DUE TO (c)  |  |  |  |   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |   |
|   |  |  |  | 20f. (City or town)   |  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Oct 20</b> , 19 <b>57</b> to <b>Oct 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 24</b> , 19 <b>58</b> , and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above. |  |  |  |   |  |   |   |
| ACTUAL SIGNATURE <b>Robert B. Harell</b>  |  |  |  | ADDRESS (Street, city or town, state) <b>5516 Nebraska Ave Washington, DC</b>   |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Robert B. Harell</b>   |  |  |  | DATE SIGNED <b>10/25/58</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10.27.58</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Maryland</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lee Emma Home Ave N.E.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Hume</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11453

CERTIFICATE OF DEATH

11534

Reg. Dist. No.

|   |                               |  |                                  |  |                                     |  |                                  |
|---|-------------------------------|--|----------------------------------|--|-------------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>7</u> |                                     |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                               |  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchoon</u>                                    |                                     |  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>   |                               |  |                                  | d. STREET ADDRESS <u>Harford St.</u>   |                                     |  |                                  |
| 3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Nicony</u> Last  |                               |  |                                  | 4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1958</u>  |                                     |  |                                  |
| 5. SEX <u>fe</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-28-96</u> | 9. AGE (In years last birthday) <u>61 yrs</u>  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS |  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               |  |                                  | 11. BIRTHPLACE (State or foreign country) <u>Hungary</u>   |                                     | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |                                  |
| 13. FATHER'S NAME <u>John Kovacs</u>  |                               |  |                                  | 14. MOTHER'S MAIDEN NAME <u>Helen</u>  |                                     |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>   |                               |  |                                  | 16. SOCIAL SECURITY NO   |                                     | 17. INFORMANT <u>Son + Hosp. Records</u> Address                       |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]   |                               |  |                                  |  |                                     |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>  |                               |  |                                  |  |                                     |  | <u>12 days</u>                   |
| Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.   |                               |  |                                  |  |                                     |  | <u>14 days</u>                   |
| (b) <u>Myocardial</u>   |                               |  |                                  |  |                                     |  |                                  |
| (c) <u>Circulatory shock</u>  |                               |  |                                  |  |                                     |  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                  |  |                                     |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                     |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               |  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                            |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                                  |
|   |                               |  |                                  | 20f. (City or town)  |                                     | (County) (State)   |                                  |
| 21. I certify that I attended the deceased from <u>10-12-58</u> , 19 <u>58</u> , to <u>10-27-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-27-58</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above. |                               |  |                                  |  |                                     |  |                                  |
| ACTUAL SIGNATURE <u>Richard L. Clapp</u>  |                               |  |                                  | ADDRESS (Street, city or town, state) <u>7606 Carroll Hill Takoma Park, Md.</u>  |                                     |  |                                  |
| PHYSICIAN'S NAME (Type) <u>RICHARD L. CLAPP</u>   |                               |  |                                  | DATE SIGNED <u>10-27-58</u>  |                                     |  |                                  |
| 22a. BURIAL CREMATION REMOVAL (Specify)   |                               | 22b. DATE THEREOF <u>Oct 30-1958</u>   |                                  | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>   |                                     | 22d. LOCATION (City, town, or county) <u>Green Lawn, Md.</u>           |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>  |                               |  |                                  | 24a. REC'D BY REGISTRAR <u>30 58</u>   |                                     | 24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>                       |                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11552

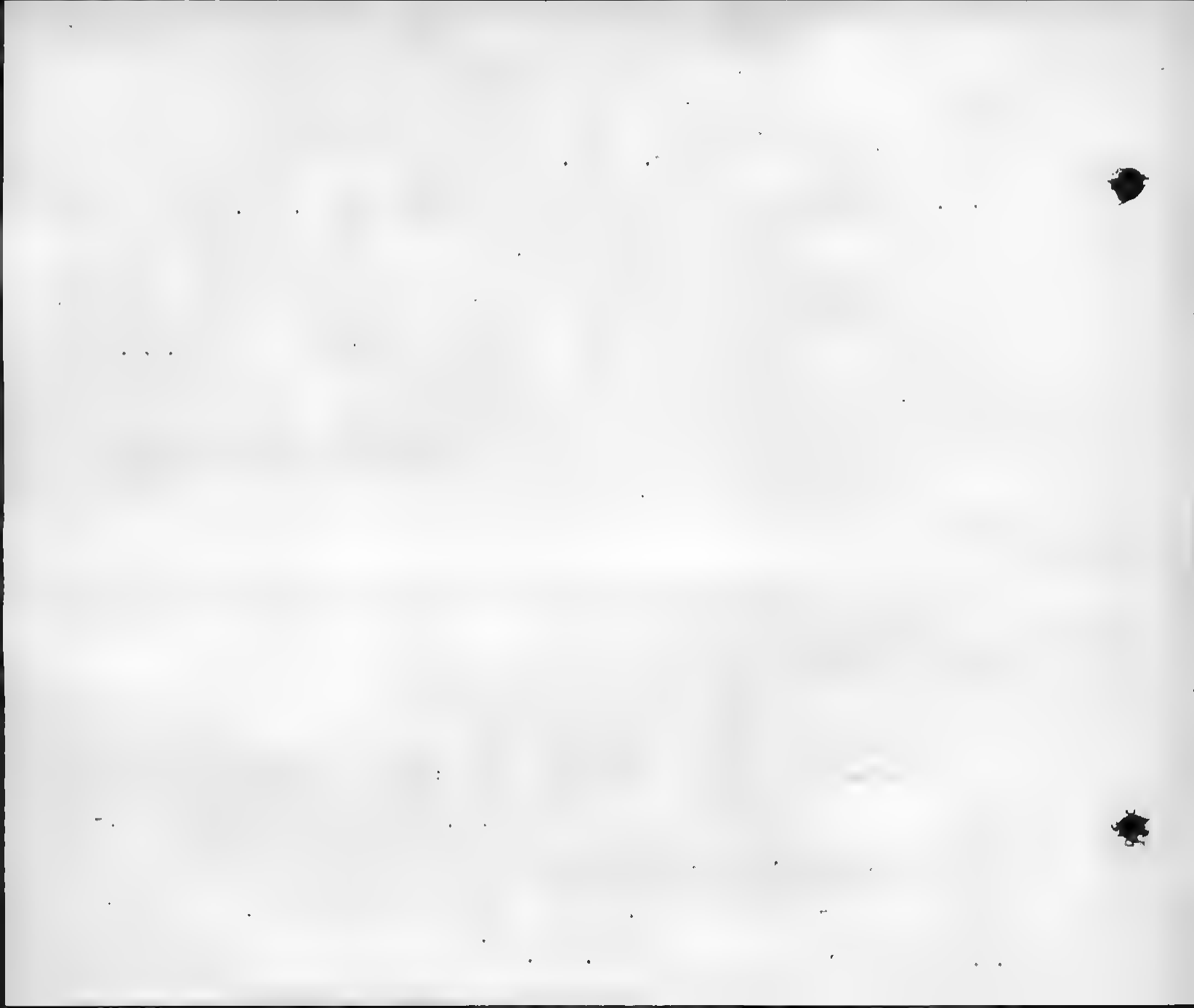
CERTIFICATE OF DEATH

11535

Reg. Dist. No. 215

|   |                                 |   |                                     |
|---|---------------------------------|---|-------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>4hr. 25min.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>U. S. Naval Hospital</b>  |                                 | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Falls Church</b><br>c. STREET ADDRESS<br><b>525 Knollwood Drive. Apt. #104</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Boy</b> Last <b>NOBLE</b>  |                                 | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>30</b> Year <b>19 58</b>  |                                     |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>10-29-58</b> |
| 9 AGE (In years last birthday)<br>yrs. <b>4</b> Months <b>4</b> Days <b>25</b>  |                                 | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                     |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>   |                                 | 11 BIRTHPLACE (State or foreign country)<br><b>Bethesda, Maryland</b>   |                                     |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                 | 13. FATHER'S NAME<br><b>Joe Bailey NOBLE</b>  |                                     |
| 14 MOTHER'S MAIDEN NAME<br><b>Joan JACKSON</b>  |                                 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     |
| 16 SOCIAL SECURITY NO.<br><b>None</b>   |                                 | 17 INFORMANT<br><b>(F) Joe Bailey Noble, same as #2 above</b>   |                                     |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Primary atelectasis</b><br>162.5 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immaturity (26 wks gestation)</b><br>DUE TO<br>(c) <b>5 hours</b>                     |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hours</b>  |                                     |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |   |                                     |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>October 29, 1958</b> , to <b>October 30, 1958</b> , that I last saw the deceased alive on <b>October 30, 1958</b> , and that death occurred at <b>2:25A M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>10-30-58</b> |                                 |   |                                     |
| ACTUAL SIGNATURE <b>David Harris</b>  |                                 | PHYSICIAN'S NAME (Type) <b>D. HARRIS, LT. MC, USN</b>   |                                     |
| 22a BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 22b DATE THEREOF<br><b>11-3-58</b>  |                                     |
| 22c NAME OF CEMETERY OR CREMATORY<br><b>Columbia Gardens Cemetery</b>   |                                 | 22d LOCATION (City town or county) (State)<br><b>Falls Church Virginia</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. Pumphrey</b>  |                                 | ADDRESS <b>Bethesda, Md.</b>  |                                     |
| 24a REC'D BY REGISTRAR<br><b>NOV 3 '58</b>  |                                 | 24b REGISTRAR'S SIGNATURE<br><b>Charles E. Hana</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





11553

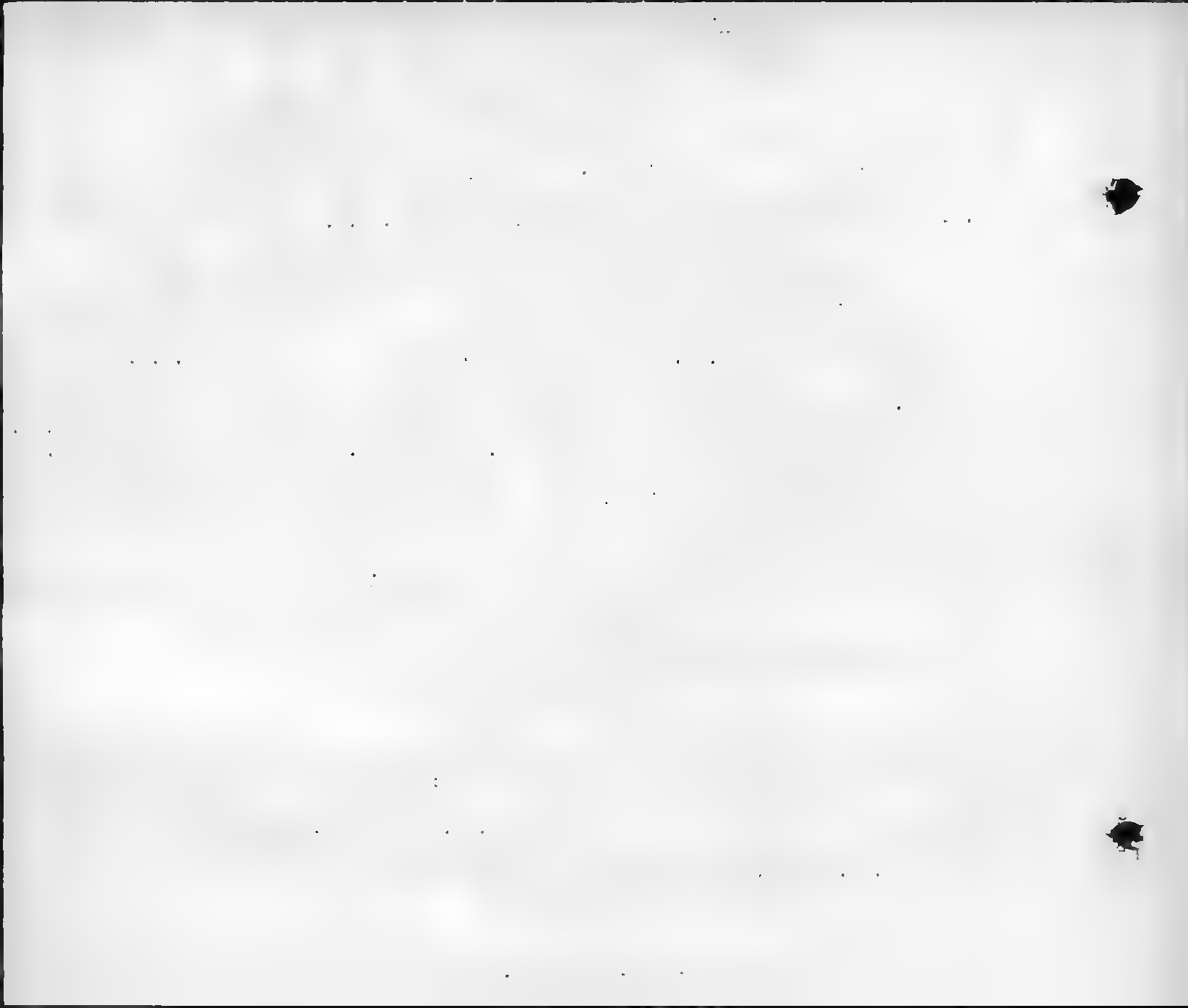
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>1yr 5mos.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>47 x 2</b><br>d. STREET ADDRESS<br><b>211 11th St. S.E.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Harry Aloysius NOLAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>26</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>11-5-83</b>   |  |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mariner</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Navy</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>               |  |
| 13. FATHER'S NAME<br><b>Henry A. NOLAN</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann RYAN</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes no or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>WWI</b>                            |  | 17. INFORMANT<br>Address <b>Landover Hills, Md.</b><br><b>(D) Mrs. Margaret A. Morris, 4711 Glen Oak Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis, generalized</b><br><b>153.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Perforated bowel</b><br>DUE TO (c) <b>Adenocarcinoma, cecum, metastatic</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b><br><b>36 hrs</b><br><b>1 year</b>                 |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I attended the deceased from <b>May 31</b> , 1957, to <b>October 26</b> , 1958, that I last saw the deceased alive on <b>October 26</b> , 1958, and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>U. S. Naval Hospital, NMMC</b> <b>10-27-58</b><br>ACTING SIGNATURE <b>H. S. IRONS, LT MC, USN</b> <b>Bethesda 14, Maryland</b><br>PHYSICIAN'S NAME (Type) |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10-30-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hanlon Funeral Home, 3831 Ga. Ave., NW, Wash. D.C.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kins</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11554

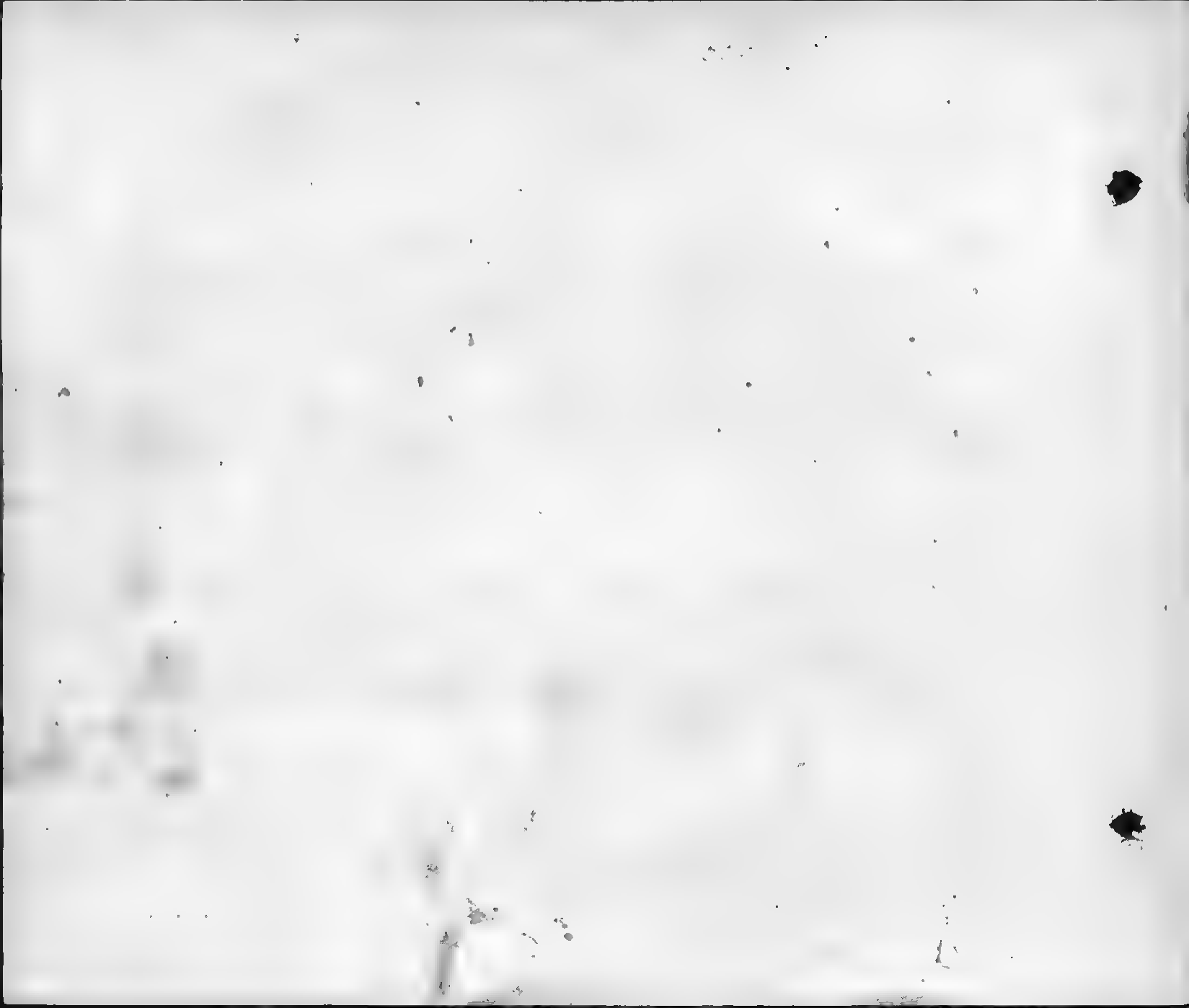
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>  |   | d. STREET ADDRESS <u>6505 - 14th St. N.W.</u> <input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <u>Katherine Burruss</u> First Middle <u>OVERSTREET</u>  |   | DATE OF DEATH <u>Oct 25 1958</u> Month Day Year   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 8. DATE OF BIRTH <u>Aug. 1 1900</u> 9. AGE (In years last birthday) <u>58</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Training Officer US Gov't</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>William Burruss</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Un-Known</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO <u>577-01-6805</u>   |   |
| 17. INFORMANT <u>William B. Overstreet</u> Address <u>3302 94th St. Kensington, Md</u>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO <u>Pulmonary Emphysema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u><br>DUE TO (c) <u></u> |   | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u><br><u>4 years</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>10/2 1955</u> to <u>10/25 1958</u> , that I last saw the deceased alive on <u>10/24 1958</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.  |   |   |   |
| ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave Wash. D.C.</u>   |   | DATE SIGNED <u>10/25/58</u>   |   |
| ACTUAL SIGNATURE <u>Frank Y. Jazgier Jr.</u> M.D.  |   |   |   |
| PHYSICIAN'S NAME (Type)  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   | 22b. DATE THEREOF <u>10.28.58</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>  | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>              |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u> ADDRESS <u>Wash. D.C.</u>   |   | 24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>  | 24b. REGISTRAR'S SIGNATURE <u>C. H. &amp; H. H. H.</u>                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The low requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



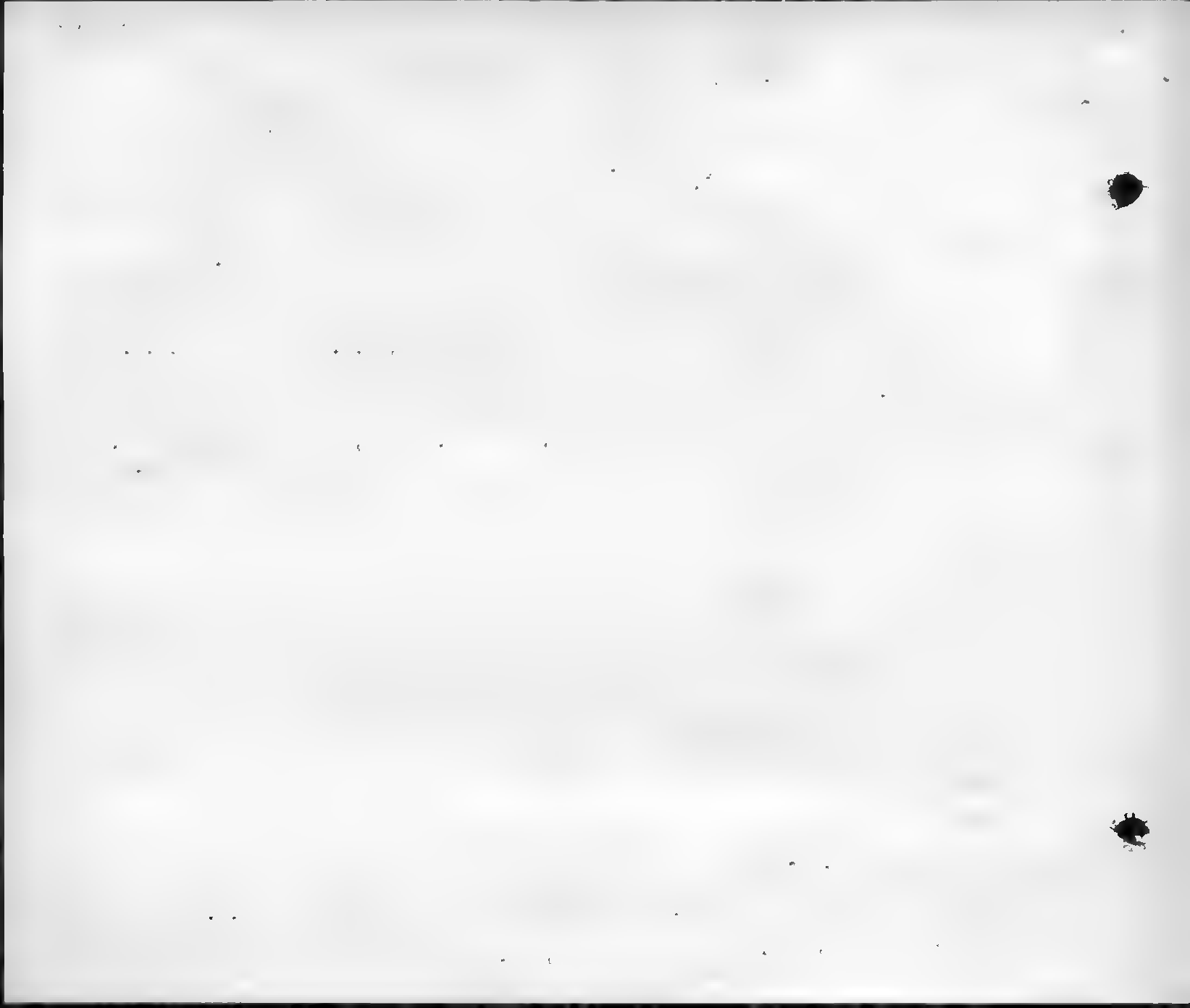
11555

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b<br><b>8 yrs.</b>   |   | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b> |  |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION<br><b>10153 SUTHERLAND ROAD</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGARET</b> Middle <b>FRANCES</b> Last <b>OWENS</b>   |   | 4. DATE OF DEATH<br>Month <b>OCT.</b> Day <b>5</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>8/22/93</b>                                       |
| 9. AGE (In years last birthday)<br><b>65</b>   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>DAVID C. ALLEN</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>ROSE ANNE CONNELLY</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  |
| 17. INFORMANT<br><b>Mr. Leroy S. Owens, 10153 Sutherland Rd.</b>   |   | Address<br><b>Silver Spring, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Hemorrhage</b><br>(c) <b>Cerebral Arteriosclerosis</b>  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <b>1/8</b> 19 <b>58</b> to <b>10/5</b> 19 <b>58</b> , that I last saw the deceased alive on <b>10/4</b> 19 <b>58</b> , and that death occurred at <b>8:10</b> P.M. from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>113 Carroll St NW Wash 12 DC</b><br>DATE SIGNED <b>10/6/58</b><br>ACTUAL SIGNATURE <b>Dean H. Harding</b> M.D.<br>NAME (Type) <b>DEAN H. HARDING</b> |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>10/8/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond L. Pumphrey, Inc.</b>   |   | ADDRESS<br><b>SILVER SPRING, MD.</b>   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 7 '58</b>                         |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11556

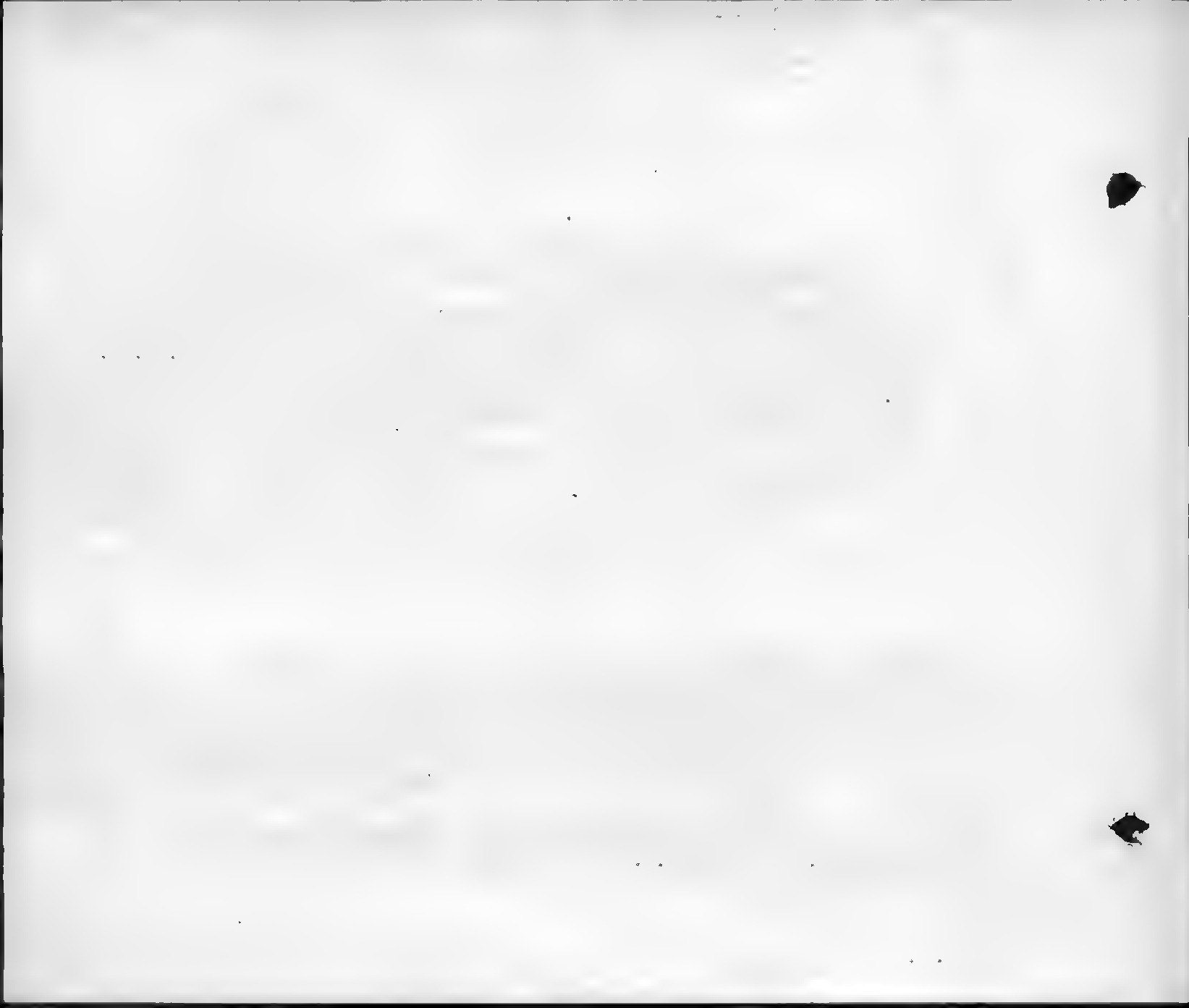
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |  |  |  |  |
|---|----------------------------------|---|---|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>62 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  |   |   | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>Alabama</b><br>b. COUNTY<br><b>Birmingham</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Birmingham</b><br>d. STREET ADDRESS<br><b>Route #3, Box 1060E</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Clyde Taylor Palmer</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 28, 1958</b> |  |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 1, 1901</b>                      |  | 9. AGE (In years last birthday)<br><b>57</b> yrs |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Coal Miner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mining</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Walter Lee Palmer</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mertie Blaylock</b>            |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes WW II</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>417-01-4281</b>  |   | 17. INFORMANT The Medical Record Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thrombophlebitis left lower extremity with</b><br><b>463X</b> DUE TO <b>inceptant gangrene</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis, Rheumatoid Heart Disease</b> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH                 |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>The Clinical Center</b>   |  |  |  |
| 20f. (City or town)<br><b>Bethesda</b>  |                                  | 20g. (County)<br><b>Montgomery</b>  |   | 20h. (State)<br><b>Md.</b>   |  |  |  |
| 21. I certify that I attended the deceased from <b>August 27, 1958</b> , to <b>October 28, 1958</b> , that I last saw the deceased alive on <b>October 28, 1958</b> , and that death occurred at <b>2:08 AM</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b><br>DATE SIGNED <b>10/28/58</b>  |                                  |   |   |  |  |  |  |
| ACTUAL SIGNATURE <b>Arnold N. Weinberg</b> M.D.   |                                  | PHYSICIAN'S NAME (Type) <b>ARNOLD N. WEINBERG, M.D.</b>   |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   |                                  | 22b. DATE THEREOF<br><b>10/29/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Birmingham, Alabama</b>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Company</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>2901 14th St. N.W. Washington 9, D.C.</b><br>DATE <b>OCT 30 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11454

## CERTIFICATE OF DEATH

Reg. Dist. No.

11541

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Grant Avenue</u>   |  | d. STREET ADDRESS <u>124 Grant Avenue</u>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>B.</u> Last <u>PHELPS</u>  |  | 4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1958</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 25, 1881</u>  |
| 9. AGE (In years last birthday) <u>77</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Henry Phelps</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Mary</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO <u>578-28-7094</u>  |  |
| 17. INFORMANT <u>Mrs Artemisia M. Phelps</u>   |  | Address <u>124 Grant Ave T.P.Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive failure - Acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Paralysis - accidental</u><br>DUE TO<br>(c) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day - 2 yrs.</u>                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>9/30</u> , <u>1958</u> , to <u>10-14</u> , <u>1958</u> , that I last saw the deceased alive on <u>10-14</u> , <u>1958</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <u>Ernest A. Sardo</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave.</u> DATE SIGNED <u>10-14-58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO</u>   |  |  |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>Oct. 17, 1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. Md 20C</u>  |  | 24. REC'D BY REGISTRAR DATE <u>OCT 16 1958</u>   | 25. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>                                 |



11542

Reg. Dist. No.

|   |  |                               |  |  |  |  |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br><b>MARYLAND</b>   |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>Montgomery</u> |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |                               |  |  |  | c. LENGTH OF STAY IN lb <u>11 days</u>   |  |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |  |                               |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Narion</u> Middle <u>Henry</u> Last <u>Philson</u>   |  |                               |  |  |  | 4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1958</u>  |  |  |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH <u>1878-28-APR</u>  |  | 9. AGE (In years last birthday) yrs. <u>80</u>                           |  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>  |  |                               |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>Pg.</u>                     |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Unknown</u>  |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>no</u>  |  |                               |  |  |  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital Record</u> |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u><br>DUE TO (b) <u>Cir Reg Myocardial infarct &amp; Decomp.</u><br>DUE TO (c) <u>Gentle hemorrhage &amp; coronary insufficiency</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |                               |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u><br><u>18 days</u>                               |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                               |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  |                               |  | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |  |  |
| 21. I certify that I attended the deceased from <u>10/15/58</u> , to <u>10/16/58</u> , that I last saw the deceased alive on <u>10/16/58</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>2030 Carroll Ave Takoma Park Md</u><br>DATE SIGNED <u>10/16/58</u>                                   |  |                               |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Howard T Morse</u> MD.  |  |                               |  |  |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>   |  |                               |  | <u>Takoma Park Md</u>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |  |                               |  | 22b. DATE THEREOF <u>10/18/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cape View Hill</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>MD</u>                  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Montmarquet Sr</u>  |  |                               |  | ADDRESS <u>5722 1st Ave</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 20 58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>                        |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11557

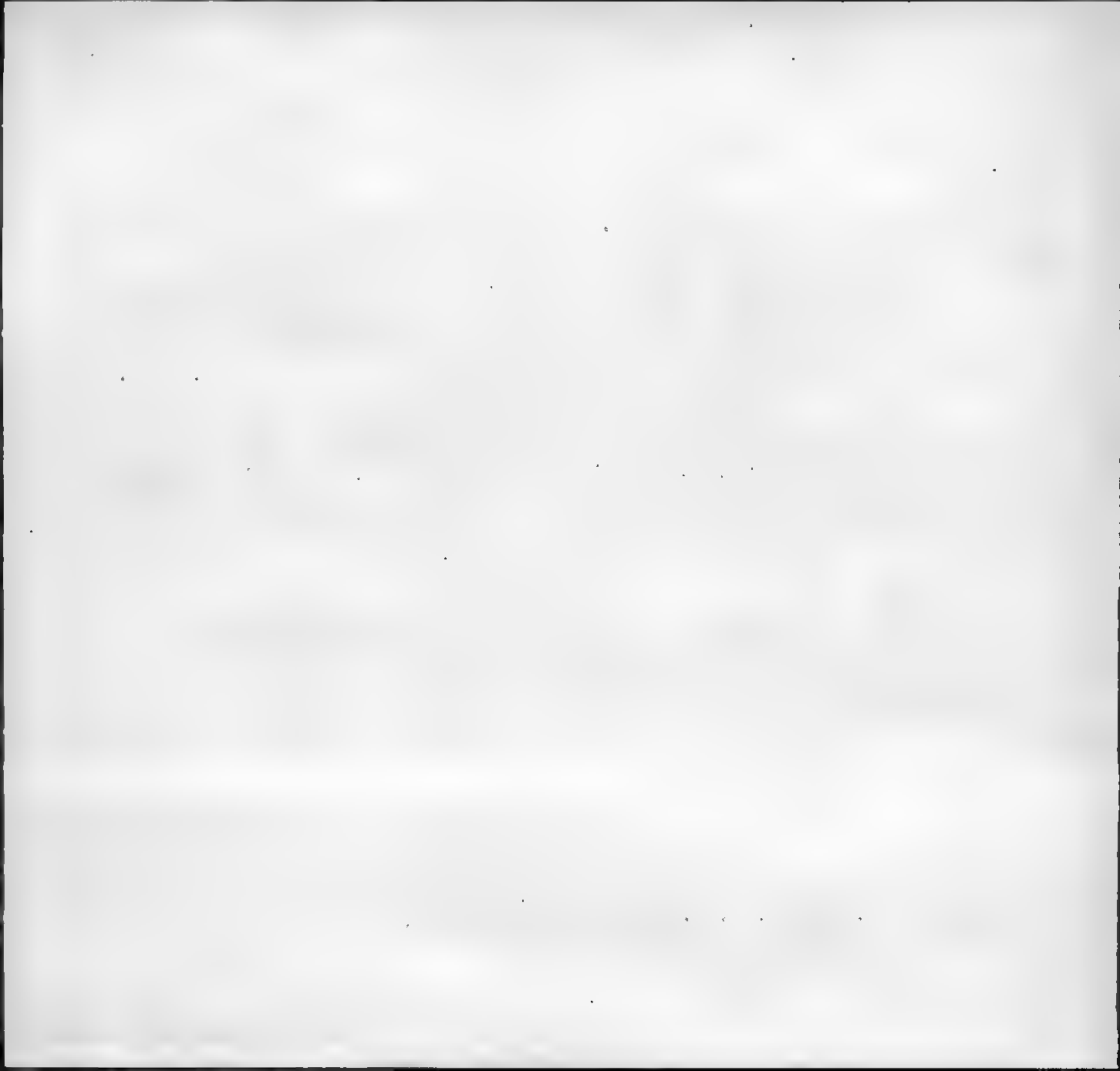
CERTIFICATE OF DEATH

11543

Reg. Dist. No.

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>12 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |   |   | d. STREET ADDRESS<br><b>2726 Hemlock Avenue</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Bertha (none) Pollack</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 18, 1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 8, 1918</b> |   | 9. AGE (In years last birthday)<br><b>40 yrs</b> | IF UNDER 1 YEAR<br>Months Days Hours Min                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Massachusetts</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                         |  |
| 13. FATHER'S NAME<br><b>Joseph Dumanis DUMANIS</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Bloomstein</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>009-01-9966</b>  |   | 17. INFORMANT<br><b>The Medical Record</b><br>Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>                                      |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage</b><br>DUE TO<br>(b) <b>Reticulum Cell Sarcoma</b><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>2 months</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Renal Failure, 2° to 18(b)</b>   |                                  |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <b>October 6, 1958</b> to <b>October 18, 1958</b> , that I last saw the deceased alive on <b>October 18, 1958</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.  |                                  |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Nathan S. Taylor M.D.</b>   |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br><b>The National Institutes of Health</b><br><b>Bethesda 14, Maryland</b> |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Nathan S. Taylor, M. D.</b>  |                                  |   |   | DATE SIGNED<br><b>10-18-58</b>  |  |   |  |
| 22a. BURIAL, CREMATON, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/20-1958</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l Memorial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Falls Church Va</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Goldberg Funeral Home Wash DC</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 20 1958</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>rd. e. k.</b>                          |  |

MEDICAL CERTIFICATION



11558

CERTIFICATE OF DEATH

11544

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>1600 High Street</u>  |  |  |  | d. STREET ADDRESS<br><u>1608 High Street</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JOSEPH</u> Middle <u>F</u> Last <u>PYLES</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>1</u> Year <u>1958</u>  |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept. 3, 1882</u>   |  |
| 9. AGE (In years last birthday)<br><u>76</u> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>William H Pyles</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Livina Paxton</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>578-07-3053</u>   |  | 17. INFORMANT<br><u>Bertha F. Pyles-wife-same as 2d</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, severe</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary sclerosis, severe</u><br>DUE TO (c) <u>Arteriosclerosis</u> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 minutes</u><br><u>1 year +</u><br><u>5 yrs +</u>      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>1953</u> to <u>Oct 1</u> , 1958, that I last saw the deceased alive on <u>Sept 4</u> , 1958, and that death occurred at <u>3:45 p. M.</u> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 D.C.</u> DATE SIGNED <u>10-1-58</u>                           |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Stewart Clapp</u>  |  |  |  | PHYSICIAN'S NAME (Type) <u>Stewart Clapp Wash 15 D.C.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>10/4/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Suitland, Maryland</u>                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 6 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles E. Kneass</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner notified and case released.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11456

## CERTIFICATE OF DEATH

Reg. Dist. No. 11545

|   |                               |  |   |   |   |  |  |
|---|-------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE _____ b. COUNTY _____ |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>   |                               |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D. C.</u>                           |   |  |  |
| c. LENGTH OF STAY IN 1b <u>7 hrs-15 min</u>   |                               |  |   | d. STREET ADDRESS <u>739 Oglethorpe St. N.E.</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>  |                               |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Racher</u> Middle _____ Last <u>Racher</u>  |                               |  |   | 4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1958</u>   |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-15-10</u>         | 9. AGE (In years last birthday) <u>48</u> yrs.  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Mgr.</u>  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY _____ |   | 11. BIRTHPLACE (State or foreign country) <u>Conn.</u>      |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |
| 13. FATHER'S NAME <u>Barney Racher</u>  |                               |  |   | 14. MOTHER'S MAIDEN NAME <u>Clara Gates</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army-W.W.II</u>   |                               |  |   | 16. SOCIAL SECURITY NO. _____   |   | 17. INFORMANT <u>Hospital Records</u> Address _____                            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                               |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>   |                               |  |   |   |   |  | <u>HOURS</u>   |
| DUE TO <u>CORONARY SCLEROSIS</u>  |                               |  |   |   |   |  | <u>YEARS</u>   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                               |  |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |   |   |   |  | 19. WAS A AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                              |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. _____ 19 _____   |                               |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>               |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   |  |
|   |                               |  |   | 20f. (City or town) _____ (County) _____ (State) _____  |   |  |  |
| 21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>October 20</u> , 1958, that I last saw the deceased alive on <u>October 20</u> , 1958, and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. |                               |  |   |   |   |  |  |
| ADDRESS (Street, city or town, state) _____ DATE SIGNED _____   |                               |  |   |   |   |  |  |
| ACTUAL SIGNATURE <u>Boris Rabkin</u>  |                               |  |   | M.D. <u>1019 University Boulevard S. Springfield, Ill.</u>  |   |  |  |
| PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>   |                               |  |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>Oct. 21, 1958</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>  |   | 22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____ |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Cunningham &amp; Sons - Wash DC</u> ADDRESS _____   |                               |  |   | 24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11559

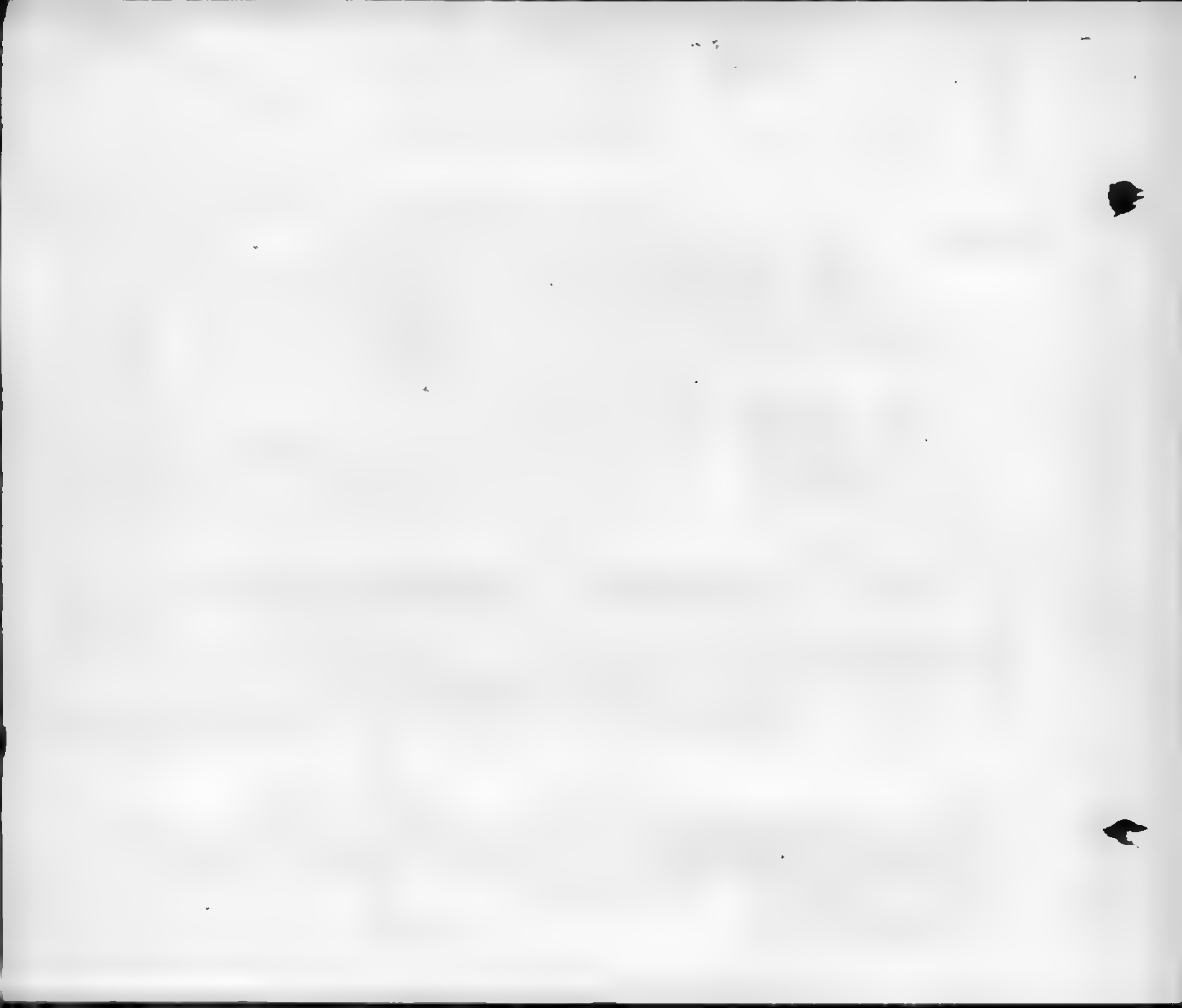
## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                           |  |   |   |                 |  |       |
|--|---------------------------|--|---|---|-----------------|--|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |                 |  |       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                           |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |                 |  |       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hosp.</u>  |                           |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 |  |       |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edgar Rawlings</u>  |                           |  |   | 4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1958</u>  |                 |  |       |
| 5 SEX <u>Male</u>  | 6 COLOR OR RACE <u>W.</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8 DATE OF BIRTH <u>February 26 1891</u> | 9 AGE (In years last birthday) <u>67</u> yrs.   | IF UNDER 1 YEAR | IF UNDER 24 HRS.   |       |
|  |                           | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |   |   | Months          | Days   | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraphic Work A.T. &amp; T.</u>  |                           |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>   |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                           |       |
| 13. FATHER'S NAME <u>John Cornelius Rawlings</u>   |                           |  |   | 14. MOTHER'S MAIDEN NAME <u>Alice Bowis</u>   |                 |  |       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                           |  |   | 16. SOCIAL SECURITY NO. <u>yes</u>  |                 |  |       |
|  |                           |  |   | 17. INFORMANT <u>Wife Dorothy M. Rawlings - Same</u> Address  |                 |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                           |  |   |   |                 |  |       |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>  |                           |  |   |   |                 |  |       |
| DUE TO (b) <u>Acute Hepatitis</u> <u>10 Day</u>  |                           |  |   |   |                 |  |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Carcinoma Ampulla of Vater</u> <u>8 Months</u>   |                           |  |   |   |                 |  |       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |   |   |                 |  |       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |   |   |                 |  |       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                           |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                 |  |       |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                           |  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |       |
|  |                           |  |   | 20f. (City or town)   |                 | (County) (State)   |       |
| 21. I certify that I attended the deceased from <u>Oct 3</u> , 19 <u>58</u> to <u>Oct 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. |                           |  |   |   |                 |  |       |
| ADDRESS (Street, city or town, state) <u>4413 Bradley Lane</u> DATE SIGNED <u>Chas Chase 15 Md</u>   |                           |  |   |   |                 |  |       |
| ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D.   |                           |  |   |   |                 |  |       |
| PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS</u>   |                           |  |   |   |                 |  |       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                           | 22b. DATE THEREOF <u>10/6/58</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>   |                 | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>  |       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>8434 La. Ave Silver Spring Md</u>  |                           |  |   | 24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>   |                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>                     |       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11547

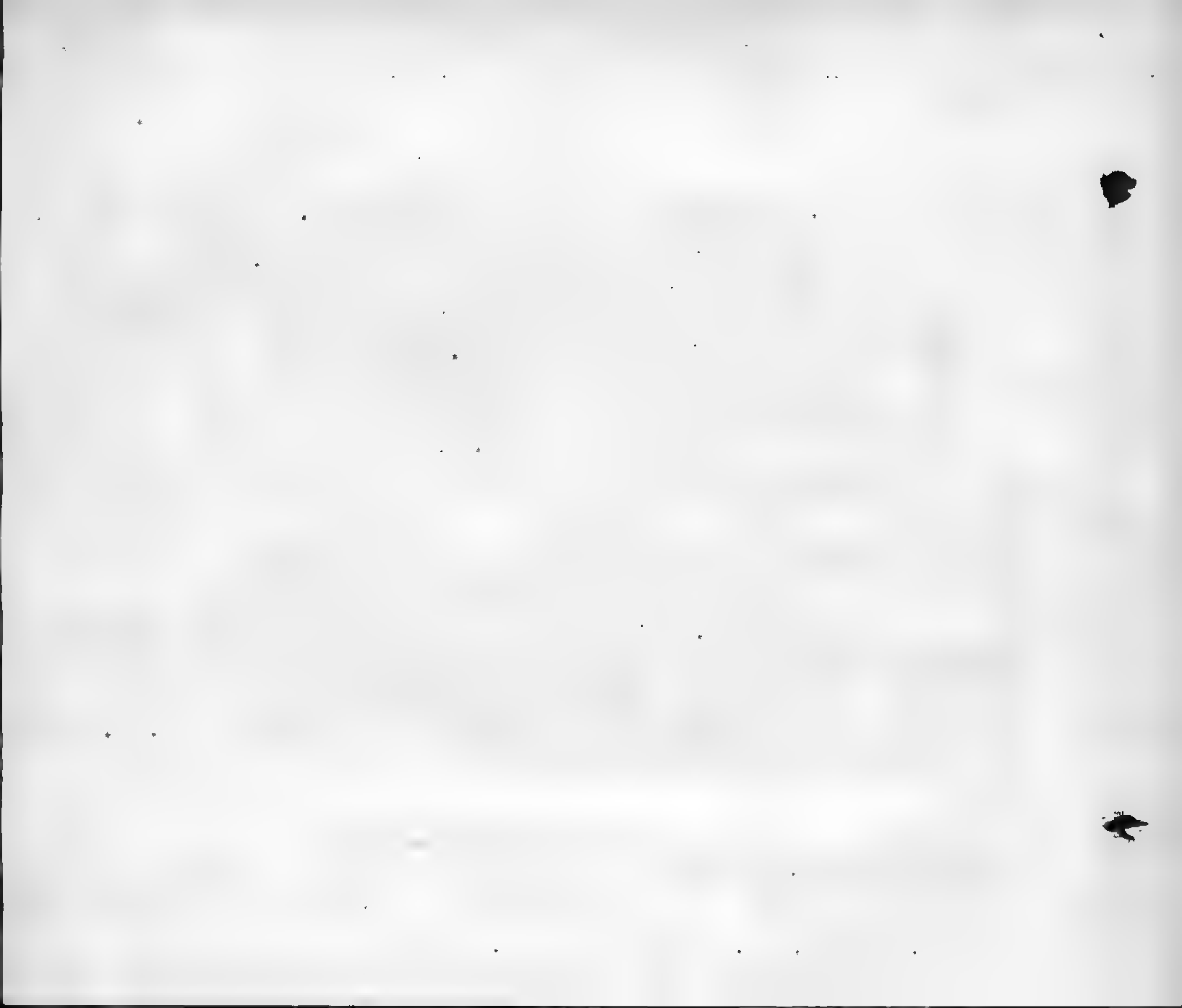
Item 13a & b, Film G-235 10/27/58.cac

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |                                  | 2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admision)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>                       |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Kensington</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington San. And Hospital</b>   |                                  | d. STREET ADDRESS<br><b>3601 Decatur Ave.</b>   |                                    |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Mary Susie Redmond</b>  |                                  | 4 DATE OF DEATH<br>Month Day Year<br><b>Oct. 8, 1958</b>  |                                    |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/2/07</b> |
| 9. AGE (In years last birthday)<br><b>51 yrs</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>19</b>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Franklin Owens</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>7 Ownes</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                    |
| 17. INFORMANT<br><b>Hosp. Record</b>  |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                                  |   |                                    |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pending</b>  |                                  |   |                                    |
| 331x DUE TO   |                                  |   |                                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                                  |   |                                    |
| (a) <b>CEREBRAL HEMORRHAGE, LEFT, MASSIVE,</b>  |                                  |   |                                    |
| (b) <b>Cerebral vascular accident</b>   |                                  |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hematoma rt. parietal region</b>   |                                  |   |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Reported collapsed in garden at home</b>                   |                                    |
| 20c. TIME OF INJURY<br>Month Day Year<br><b>10/7/58</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>home</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Kensington Montg. Md.</b>  |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                    |
| ACTUAL SIGNATURE<br><b>Frank J. Broschart</b>   |                                  | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                    |
| EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                    |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  | DATE SIGNED<br><b>10/8/58</b>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>10/11/58</b>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>ANDREW CHAPEL CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>ANDREW CHAPEL, VIRGINIA</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond A. Ziska</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 14 '58</b>  |                                    |
| 24b. REGISTRAR'S SIGNATURE<br><b>Clint S. Kuma</b>  |                                  |   |                                    |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

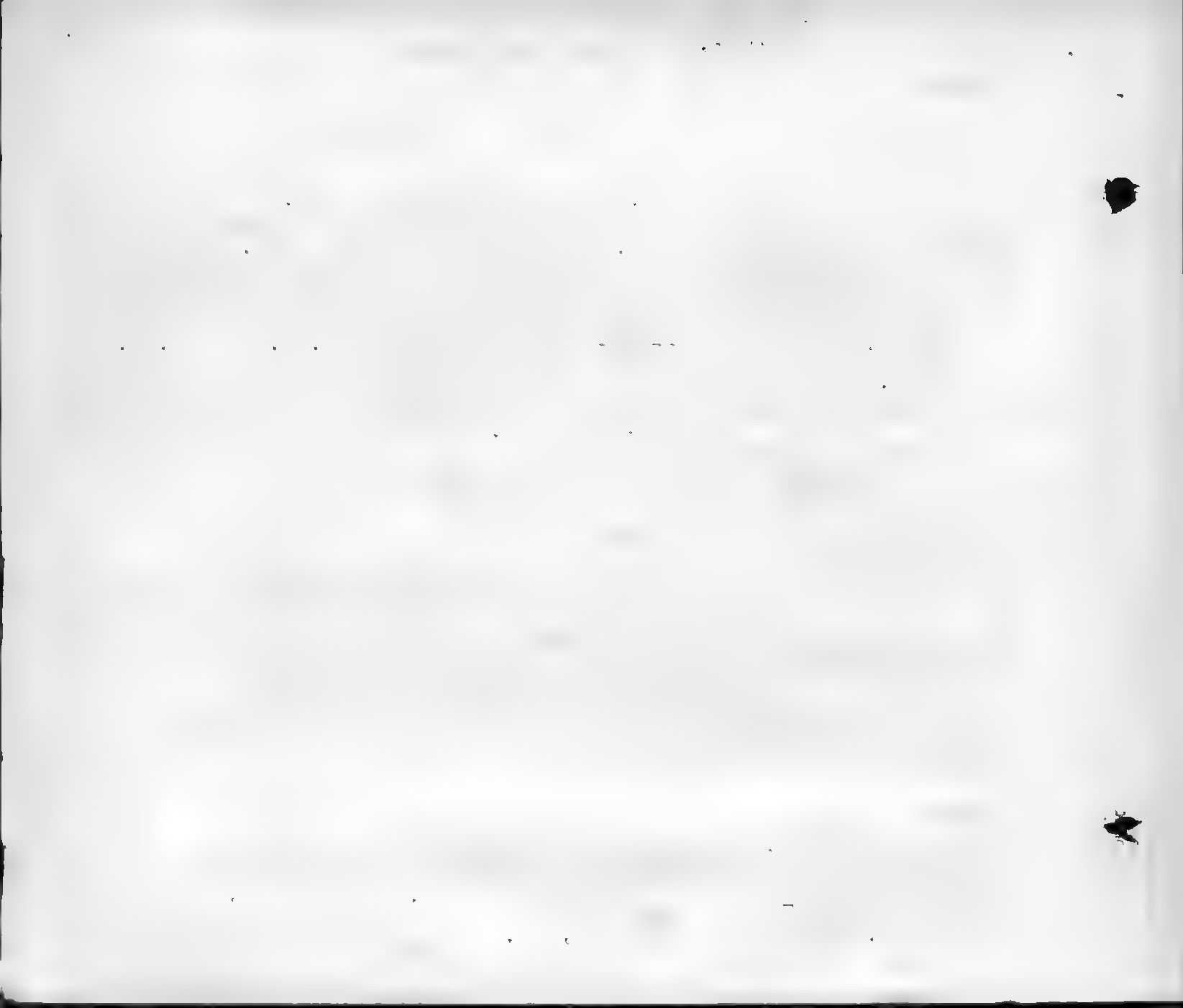
11560 CERTIFICATE OF DEATH

11548

Reg. Dist. No.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>Bethesda</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4616 Rosedale Ave.</b>  |                                     | d. STREET ADDRESS<br><b>4616 Rosedale Ave.</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BENJAMIN</b> Middle <b>S.</b> Last <b>REED</b>   |                                     | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>5,</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 22, 1881</b>                                   |
| 9. AGE (In years last birthday)<br><b>77</b>   |                                     | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>13</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min <b></b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired.</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                                     |   |  |
| 13. FATHER'S NAME<br><b>John J. Reed</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)<br><b>yes</b> <b>WW I</b>   |                                     | 16. SOCIAL SECURITY NO<br><b>578-0500310</b>  |  |
| 17. INFORMANT<br><b>Daughter</b>   |                                     | Address<br><b>Mrs. Betty Thompson</b>   |  |
| Item<br><b>Same as #2</b>  |                                     |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary aocl.</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>unk.</b> |                                     |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>1949</b> , 19 <b>58</b> , to <b>5 Octob.</b> 19 <b>58</b> , that I last saw the deceased alive on <b>29 Sept.</b> 19 <b>58</b> , and that death occurred at <b>6 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7659 Georgetown Rd. - Bethesda 14, Md.</b><br>DATE SIGNED <b>6 Oct 58</b>   |                                     |   |  |
| ACTUAL SIGNATURE<br><b>John M. Wyman</b>   |                                     | M.D. <b>John M. Wyman</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>John M. Wyman</b>  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-8-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cem.</b>   | 22d. LOCATION (City, town or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |                                     | ADDRESS<br><b>Bethesda, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>D OCT 8 '58</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>C. L. S. House</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11561

CERTIFICATE OF DEATH

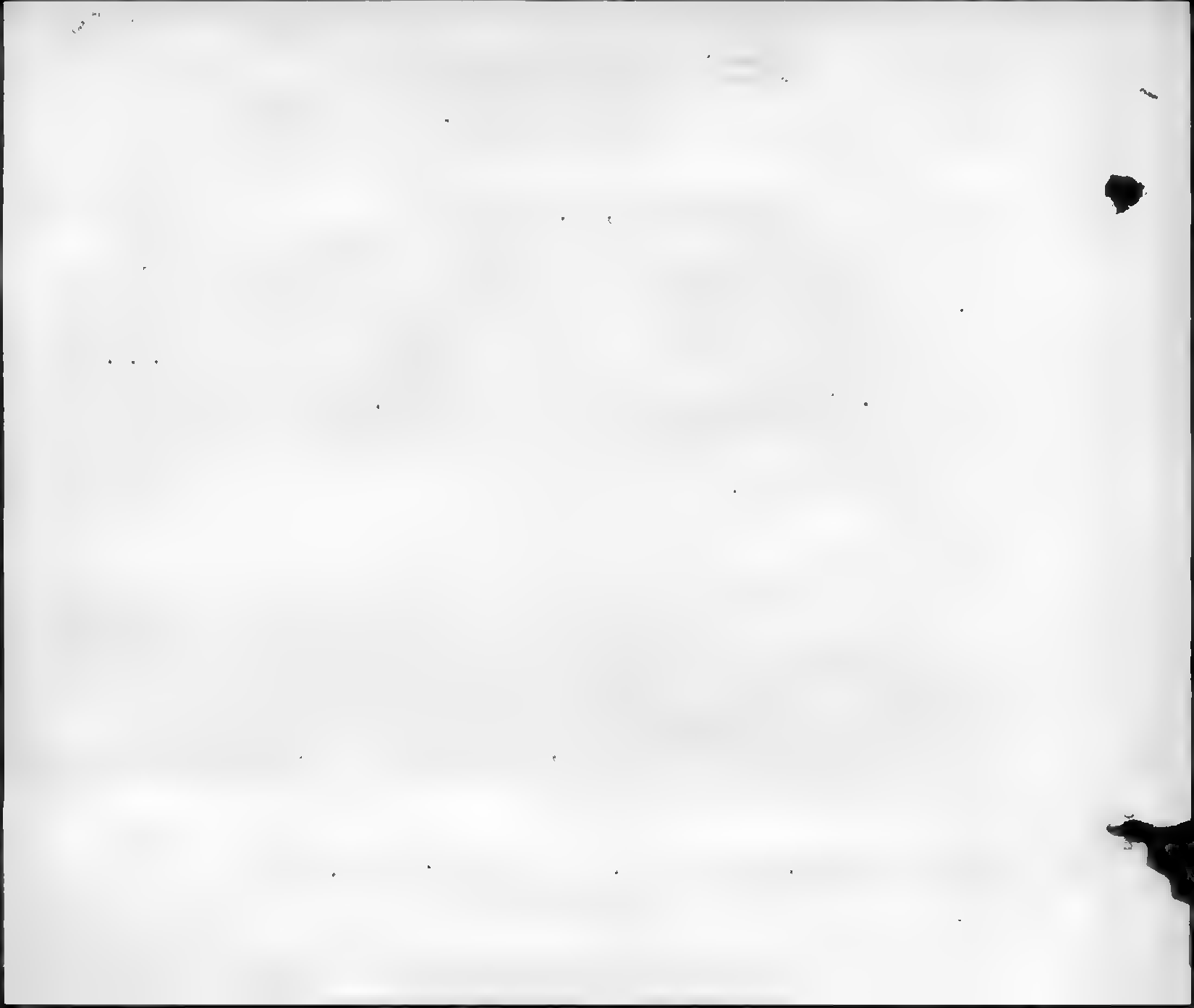
11549

Reg. Dist. No.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>Alabama</b> b. COUNTY |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  |   | c. LENGTH OF STAY IN 1b<br><b>96 days</b>  |  |   |
| d. NAME OF HOSPITAL (if not in hospital) give street address<br>OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Betty</b> Middle <b>Jo</b> Last <b>Reed</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>13</b> Year <b>19 58</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 25, 1923</b>  | 9. AGE (In years last birthday)<br><b>35 yrs</b>                   | IF UNDER 1 YEAR<br>Months Days Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>                                       |
| 13. FATHER'S NAME<br><b>William E. O'Shields</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mattie L. Garrett</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>422-22-8266</b><br><b>unknown</b>  |  |   |
| 17. INFORMANT<br><b>The Medical Record</b>  |                                  |   | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b><br><b>173x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Choriocarcinoma</b> DUE TO<br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 years</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21. I certify that I attended the deceased from <b>July 9, 1958</b> to <b>October 13, 1958</b> , that I last saw the deceased alive on <b>October 13, 1958</b> , and that death occurred at <b>3:10 PM</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>10/13/58</b>   |                                  |   |  |  |   |
| ACTUAL SIGNATURE <b>Donald A. Kellogg</b> M.D.  |                                  | PHYSICIAN'S NAME (Type) <b>DONALD A. KELLOGG, M.D.</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-Transit 10/14/58</b>  |                                  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Collinsville Cemetery</b> |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>DeKalb County, Alabama</b>  |                                  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>   |  |  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 15 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kious</b>  |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



11562

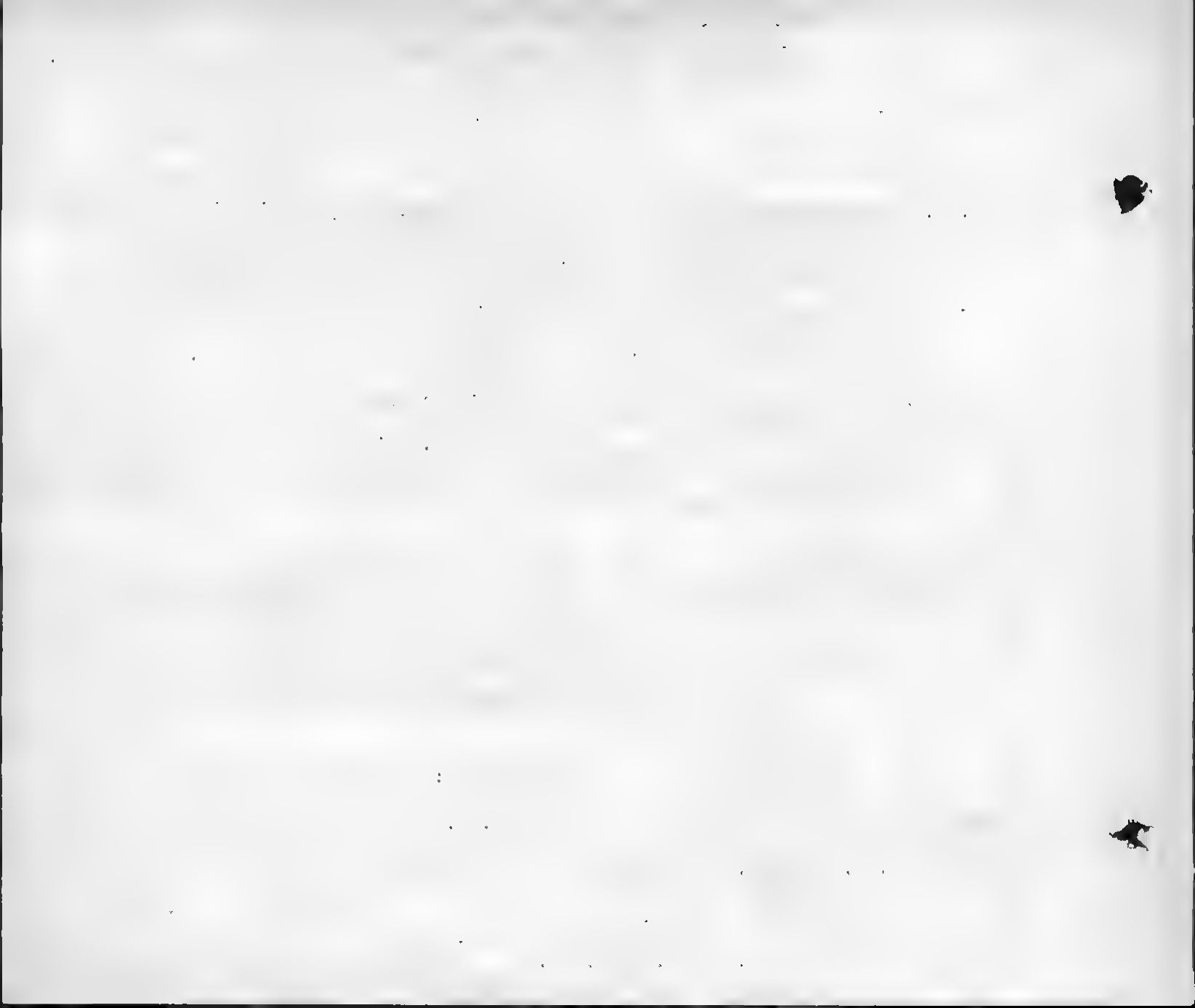
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>4 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital, NNMIC</b>                                      |   | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Alexandria</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>Alexandria</b><br>d. STREET ADDRESS<br><b>409 Daphne Lane, Hollin Hills</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Baby Boy</b> Middle <b>REICHEL</b> Last <b>REICHEL</b>  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>14</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>10-10-58</b>             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - -</b>   | 9. AGE (In years last birthday) yrs<br><b>4</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bethesda, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Alfred Julius REICHEL</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Doris Valerie SCHUCK</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO<br><b>None</b>   |   |
| 17. INFORMANT<br><b>(F) Alfred J. Reichel, same as #2 above</b>  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                       |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)            |
| 21. I certify that I attended the deceased from <b>October 10, 1958</b> , to <b>October 14, 1958</b> , that I lost saw the deceased alive on <b>October 14, 1958</b> , and that death occurred at <b>2:45A M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMIC</b> DATE SIGNED <b>10-14-58</b> |   |   |   |
| ACTUAL SIGNATURE <b>Howard A. Pearson</b>  |   | PHYSICIAN'S NAME (Type) <b>H. A. PEARSON, LT, MC, USN</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 22b. DATE THEREOF<br><b>10-16-58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   | 22d. LOCATION (City town or county) (State)<br><b>Arlington Virginia</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Demaine Memorial Chapel, 520 S. Wash. St.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>OCT 15 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11563

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |   |  | c. LENGTH OF STAY IN 1b  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>   |  |   |  | d. STREET ADDRESS <u>12723 Atherstone Drive</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Elizabeth Remines</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>27</u> Year <u>1958</u>   |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>February 21 1902</u>                               |  |
| 9. AGE (In years last birthday) <u>58</u> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <u>8</u> Days <u></u> Hours <u></u> Min <u></u> |  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13. FATHER'S NAME <u>Chas. Freed</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>Harold Remines</u> Address <u>Husband - Same</u>      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of larynx with</u><br><u>175x</u> DUE TO (b) <u>local &amp; distal metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u><br>INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month <u></u> Day <u></u> Year <u>19</u><br>Hour <u></u> a. m. <u></u> p. m. <u></u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>10-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-23-58</u> , 19 <u></u> , and that death occurred at <u>9:35</u> P. M. from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <u>11602 Georgia Ave Silver Spring Md.</u> DATE SIGNED <u>10-23-58</u>        |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Maria Remines</u> M.D. <u>11602 Georgia Ave</u>  |  |   |  | PHYSICIAN'S NAME (Type) <u>Silver Spring Md.</u>   |  |  |  |
| 22a. BURIAL CREMATION, <u>Burial</u> (Specify)   |  | 22b. DATE THEREOF <u>10-25-58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>   |  | 22d. LOCATION (City, town or county) (State) <u>Bladensburg, Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee &amp; Sons</u> ADDRESS <u>Washington, D.C.</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>OCT 27 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

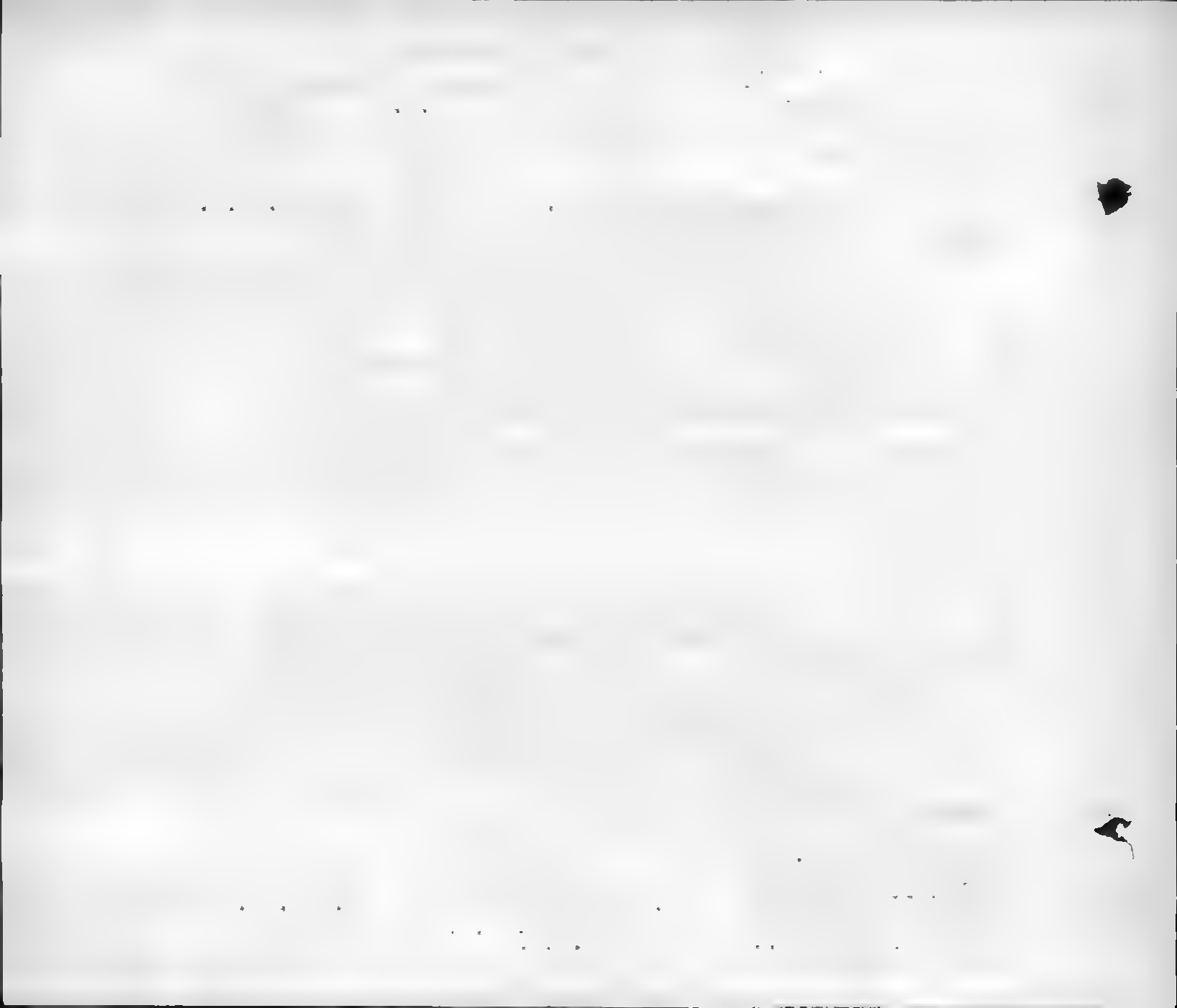
11552

11458

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY                                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>9 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>WASHINGTON SANITARIUM &amp; HOSP.</b>   |  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b> <b>4782</b>  |  |  |  |
| f. STREET ADDRESS<br><b>5318 COLORADO AVE. N.W.</b>  |  |  |  | 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELIZABETH</b> Middle Last <b>RITCHIE</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>10</b> / Day <b>9</b> Year <b>1958</b>  |  |  |  |
| 5. SEX <b>fe.</b>  |  | 6. COLOR OR RACE <b>wh.</b>            |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/5/86</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |  | IF UNDER 1 YEAR: Months Days Hours Min |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Dept of Agriculture</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pa.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>John P. Ritchie</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Liley</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>PT's Hory. Record</b> Address                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>Coronary Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>10 yrs.</b><br>(c) |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b>  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month. Day. Year 19  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |  |  |  | (County)   |  | (State)  |  |
| 21. I certify that I attended the deceased from <b>29 SEPT. 1958</b> to <b>9 OCT. 1958</b> that I last saw the deceased alive on <b>9 OCT. 1958</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Lee B. Snow</b>   |  |  |  | ADDRESS (Street, city or town, state)<br><b>9013 FLOWER AVE. SILVER SPRING, MD</b>   |  |  |  |
| DATE SIGNED<br><b>10/9/58</b>  |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Lee B. Snow</b>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF                      |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| <b>cremation</b>   |  | <b>10/10/58</b>                        |  | <b>Ft. Lincoln Crematory</b>   |  | <b>Pr. Geo. Co., Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H.Hines Co., 2901 14th St. N.W.</b>   |  |  |  | ADDRESS<br><b>Wash, D.C.</b>   |  | 24c. REC'D BY REGISTRAR<br>DATE <b>OCT 14 58</b>                       |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kiana</b>   |  |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11553

FOR STATE  
HEALTH DEPT.

11459

Reg. Dist. No.

|  |   |  |                                    |
|--|---|--|------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                   |                                    |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |   | c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8624 Flower Ave</u>  |   | d. STREET ADDRESS <u>8624 Flower Ave</u>   |                                    |
| 3 NAME OF DECEASED<br>(Type or print) <u>Violet</u>  | First <u>Love</u> Middle <u>Roberta</u> Last <u>Roberts</u> | 4 DATE <u>DEATH</u> <u>Oct</u> 7 1958  |                                    |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u>                               | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-29-1905</u> |
| 9. AGE (in years last birthday) <u>52</u> yrs.   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stationer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dep't Agri.</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Ala.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>   |                                    |
| 13. FATHER'S NAME <u>Sullivan</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Traversa</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |   | 16. SOCIAL SECURITY NO. <u>577-38-5663</u>   |                                    |
| 17. INFORMANT <u>Richard Roberts</u>   |   | Address <u>Hogues Stn 2</u>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |   |  |                                    |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>  |   |  |                                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Cardiac</u>   |   |  |                                    |
| (c) <u>dead in bed</u>   |   |  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |                                    |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>   |   | 22b. DATE THEREOF <u>10/9/58</u>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>  |   | 22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u> INC.  |   | 24a. REC'D BY REGISTRAR <u>Oct 9 '58</u>   |                                    |
| ADDRESS <u>Silver Spring, Md.</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Carlton &amp; House</u>  |                                    |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "Your copy, waiting" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11564

Items 8,9 Film 6235 10-28-58 et

CERTIFICATE OF DEATH

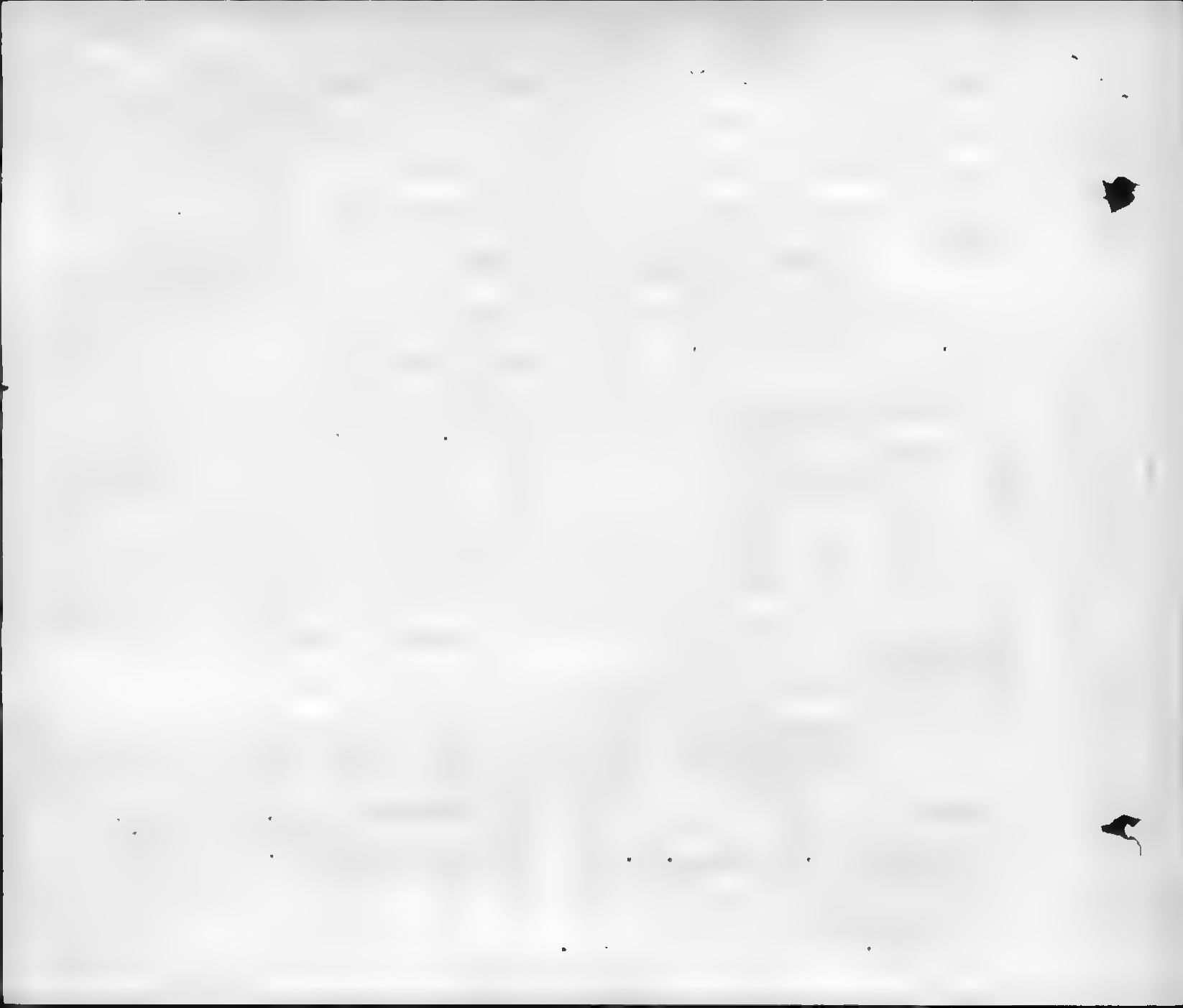
11554

Reg. Dist. No.

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>d. STREET ADDRESS <b>4702 Rosedale Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Horatio</b> Middle <b>R</b> Last <b>Rogers</b>  |                               | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>1958</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>December 12, 1900</b><br>9. AGE (In years last birthday) <b>57</b> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Arthur Rogers</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Cornelia Arnold</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes WW I &amp; II</b>  |                               | 16. SOCIAL SECURITY NO. <b>WW I &amp; II</b>  |  |
| 17. INFORMANT <b>Helen P. Rogers-Item# 2</b>  |                               | Address   |  |

|  |   |  |
|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>bronchogenic carcinoma</b><br>DUE TO (c)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>20 mos.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)                    |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <b>July 10, 1949</b> to <b>October 24, 1958</b> , that I last saw the deceased alive on <b>23 Oct</b> , 19 <b>58</b> , and that death occurred at <b>4:19</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7659 Georgetown Rd., Bethesda, Md.</b><br>DATE SIGNED <b>10/24/58</b> |   |  |
| ACTUAL SIGNATURE <b>John M. Wyman</b><br>PHYSICIAN'S NAME (Type) <b>John M. Wyman, M. D.</b>   |   | 7659 Georgetown Rd., Bethesda, Md.   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>10/28/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>   |
| 22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>   |   | 24a. REC'D BY REGISTRAR <b>Oct 27 '58</b><br>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director.



11555

FOR STATE  
HEALTH DEPT

Reg. Dist. No.

|  |                               |   |                                 |
|--|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before adm.)<br>a. STATE <u>md.</u> b. COUNTY <u>Montg.</u>                                       |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yantherbury</u>   |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>  |                               | d. STREET ADDRESS <u>R. 7 S. * 2</u>  |                                 |
| 3. NAME OF DECEASED (Type or print) First <u>Elliss</u> Middle <u>Russell Jr.</u> Last <u>Russell</u>  |                               | 4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1958</u>  |                                 |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8. DATE OF BIRTH <u>9-18-58</u> |
| 9. AGE (in years last birthday) <u>0</u> yrs   |                               | 10. IF UNDER 1 YEAR <u>0</u> Months <u>29</u> Days  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                 |
| 13. FATHER'S NAME <u>Elliss Russell</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Ruby Frazier</u>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give unit or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>Hosp. Record</u>   |                                 |
| 17. INFORMANT <u>Hosp. Record</u>  |                               | Address   |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                               |   |                                 |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u>   |                               |   |                                 |
| DUE TO (b) <u>Upper Respiratory Infection</u>  |                               |   |                                 |
| DUE TO (c) <u>3 days</u>   |                               |   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |                                 |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |                                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                 |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                 |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |                                 |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>   |                               | DATE SIGNED <u>10-18-58</u>   |                                 |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |                               | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>10-19-58</u>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Seals Farm Cemetery</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Etchison, Md.</u>  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Carlton S. Kline</u>   |                               | 24a. REC'D BY REGISTRAR <u>DATE OCT 24 '58</u>  |                                 |
| ADDRESS <u>Laytonsville, Md.</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>  |                                 |

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15ME  
■A 2:57

2073243xy.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11582 CERTIFICATE OF DEATH

11577

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clary</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>3 1/2 weeks</u> x Manor Club  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookridge Chronic Hosp</u>  |  |  |  | e. STREET ADDRESS <u>4004 Iscortly Rd</u>  |  |   |  |
| 3 NAME OF DECEASED (Type or print) <u>Mrs. Anna B. Saltman</u>   |  |  |  | 4. DATE OF DEATH <u>Oct 23 1958</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Dec 9-1880</u>                                      |  |
| 9. AGE (In years last birthday) <u>77</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>St. Louis, MO - U.S.A.</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |  |  | 13. FATHER'S NAME <u>Frank Bruno</u>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME <u>Mary Meek</u>  |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |   |  |
| 16. SOCIAL SECURITY NO   |  |  |  | 17. INFORMANT <u>Mrs. S. H. Burgess</u> Address <u>4004 Iscortly Rd. Manor Club, 5th Day</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>334X</u> <u>Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u><br>DUE TO (c) <u>Hypertension Salt</u> |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>years</u><br><u>weeks</u>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)  |  |  |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <u>9/29/58</u> to <u>10/23/58</u> that I last saw the deceased alive on <u>10/23/58</u> at <u>12:15</u> AM, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>10/23/58</u> DATE SIGNED <u>19 Maylan</u>  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>JMB</u> M.D. <u>Sandberg</u>   |  |  |  | PHYSICIAN'S NAME (Type) <u>Dr. J. L. Fuld</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>10/25/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince Georges County, Md.</u>   |  | 22d. LOCATION (City, town, or county) (State)                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. F. Hines Co 2901-14th St NW</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DATE OCT 24 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>C. H. Hines</u>                           |  |





## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11566

## CERTIFICATE OF DEATH

11556

Reg. Dist. No.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 YRS</b>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>8611 LYNNBROOK DR.</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>   |  |  |   |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARGARET CRAWFORD SARGENT</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>10 13 1958</b>   |  |  |   |
| 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JULY 13, 1875</b>   |   |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.<br><b>3 0 0 0</b> |  |   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>GOVERNMENT EMPLOYEE, RETIRED</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GOVERNMENT EMPLOYEE, RETIRED</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>HARRY CARROLL SARGENT</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET CRAWFORD BIDDLE</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO<br><b>NONE</b>   |  | 17. INFORMANT<br><b>SEN. CRAWFORD C. SARGENT</b> Address <b>8611 LYNNBROOK DR BETHESDA, MD</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b>   |  |   |  |   |  |  | <b>72 hrs</b>   |
| DUE TO (b) <b>Senility and emaciation</b>  |  |   |  |   |  |  | <b>1 year</b>   |
| DUE TO (c) <b>Arteriosclerosis, generalized</b>  |  |   |  |   |  |  | <b>5 years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Degenerative arthritis, generalized</b>  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |   |
|  |  |   |  | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <b>Sept. 18, 1958</b> to <b>Oct. 13, 1958</b> , that I last saw the deceased alive on <b>October 11, 1958</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>Robert H. Goale</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>4630 Montgomery Ave. Bethesda Md</b>  |  |  |   |
| DATE SIGNED<br><b>10/13/58</b>   |  |   |  |   |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>ROBERT N GOALE MD</b>  |  |   |  | ADDRESS<br><b>4630 MONTGOMERY AVE BETHESDA MD</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/14/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Philadelphia, Penn.</b>                    |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |   |  | ADDRESS<br><b>Bethesda, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>  |   |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11466 CERTIFICATE OF DEATH

11557

Reg. Dist. No.

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5608 Randolph Road</b>  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>A</b> Last <b>SAUTER</b>   |                                   | 4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>1958</b>  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 16, 1877</b>                                   |
| 9. AGE (In years last birthday) <b>81</b> yrs.  |                                   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>26</b> Hours <b></b> Min <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Bus College</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>John S. Gilliss</b>  |                                   | 14. MOTHER'S MAIDEN NAME <b>Leanna Ricketts</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give year or dates of service)  |                                   | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 17. INFORMANT <b>Miss Myrtle Gilliss -sister-</b>   |                                   | 18. ADDRESS <b>5608 Randolph Rd., Rockville, Md</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral-vascular disease (hemorrhage)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>Unknown</b> |                                   | INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>   |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>December, 1956</b> , to <b>October 12, 1958</b> , that I last saw the deceased alive on <b>October 11, 1958</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.  |                                   |  |  |
| ACTUAL SIGNATURE <b>Aaron H. Traum</b>  |                                   | ADDRESS (Street, city or town, state) <b>8237 Georgia Ave. Silver Spring, Md.</b> DATE SIGNED <b>Oct 12, 1958</b>  |  |
| INFORMANT'S NAME (Type) <b>Aaron H Traum</b>  |                                   | <b>8237 Georgia Ave. Silver Spring, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>10/15/58</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>  |                                   | 24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 235 10-31-58

## CERTIFICATE OF DEATH

Reg. Dist. No.

11558

11567

|  |  |                           |  |   |  |                             |  |   |  |  |  |  |  |  |  |
|--|--|---------------------------|--|---|--|-----------------------------|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  |                           |  | MARYLAND  |  |                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Virginia |  |  |  | b. COUNTY<br>Alexandria  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |  |                           |  | c. LENGTH OF STAY IN 1b<br>4½ months  |  |                             |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br>Alexandria              |  |  |  | 8.3  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. Naval Hospital   |  |                           |  | d. STREET ADDRESS<br>1710 Crestwood Drive   |  |                             |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>Donald Theodore SCHWOB  |  |                           |  | First Middle Last   |  |                             |  | 4. DATE OF DEATH<br>October 8 19 58   |  |  |  | Month Day Year   |  |  |  |
| 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>4-15-08 |  | 9. AGE (In years last birthday)<br>50 yrs   |  | IF UNDER 1 YEAR: Months Days Hours Min |  | IF UNDER 24 HRS  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Foreign Service Officer   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. State Dept.   |  |                             |  | 11. BIRTHPLACE (State or foreign country)<br>W. Virginia  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |  |  |  |
| 13. FATHER'S NAME<br>Oliver O. SCHWOB  |  |                           |  | 14. MOTHER'S MAIDEN NAME<br>Bettha P. SHEETS  |  |                             |  |   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)<br>No   |  |                           |  | 16. SOCIAL SECURITY NO<br>317-10-6047   |  |                             |  | 17. INFORMANT<br>Wife, Mrs. Ruth H. Schwob, same as #2 above  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory esophageal cancer</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>P. O. P. hypertension</u><br>DUE TO <u>Carcinoma of liver</u><br>(c) <u>Metastatic carcinoma, lung, bilateral.</u> |  |                           |  |   |  |                             |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.                                |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Metastatic carcinoma, lung, bilateral.  |  |                           |  |   |  |                             |  |   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |                             |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |                             |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)                                     |  |  |  |
| 21. I certify that I attended the deceased from May 16 1958, to October 8 1958, that I last saw the deceased alive on October 8 1958, and that death occurred at 9:25 P M, from the causes and on the date stated above.   |  |                           |  |   |  |                             |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>J. T. Horgan   |  |                           |  | M. D.<br>U. S. Naval Hospital, NMMC   |  |                             |  | DATE SIGNED<br>10-9-58  |  |  |  | ADDRESS (Street, city or town, state)                                    |  |  |  |
| PHYSICIAN'S NAME (Type)<br>J. T. HORGAN LT MC USN  |  |                           |  | Bethesda 14, Maryland   |  |                             |  |   |  |  |  |  |  |  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  |                           |  | 22b. DATE THEREOF<br>10-13-58   |  |                             |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Local Cemetery  |  |  |  | 22d. LOCATION (City, town, or county) (State)<br>Moundsville W. Virginia |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Adams Funeral Home, 4748 Wisconsin Ave., N.W.  |  |                           |  | ADDRESS Washington, D.C.  |  |                             |  | 24a. REC'D BY REGISTRAR<br>DATE OCT 10 '58  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Frank                            |  |  |  |









TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11569

CERTIFICATE OF DEATH

11560

Reg. Dist. No.

|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Springs</b>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oxon Hill</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Fairland Nursing Home</b>   |                                  |   |   | d. STREET ADDRESS<br><b>5669--Bock Terrace</b>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SUSIE</b> Middle <b>ELLENA</b> Last <b>SCOTT</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>10</b> Year <b>1958</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 29-1860</b> |   | 9. AGE (In years last birthday)<br><b>98</b> yrs. |   | IF UNDER 1 YEAR<br>Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Novelty Shop</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Williams T. Simmons</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary C. ?</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |   | 17. INFORMANT<br><b>Albert C. Scott 5669--Bock Terr. S.E.</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Senility</b><br>DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>DUE TO _____<br>(c) _____ |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fracture left hip (Aug 21 1958)</b>   |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour a. <b>9</b> p. m. Month, Day, Year <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that I attended the deceased from <b>Sept 8</b> , 19 <b>58</b> , to <b>Oct 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 9</b> , 19 <b>58</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.  |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Araron H. Trauer</b> M.D.   |                                  |   |   | ADDRESS (Street, city or town, state) <b>8237 Georgia Ave - Silver Spring Md 20910</b>  |   |   |  |
| PHYSICIAN'S NAME (Type) _____   |                                  |   |   | DATE SIGNED <b>10/10/58</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-13-58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>  |   | 22d. LOCATION (City, town, or county) _____ (State) <b>Va</b>                                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Samuel Bro.</b>  |                                  |   |   | ADDRESS<br><b>1661- Good Hope Rd SE<br/>L.W. 4th. 20102</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 1958</b>  |  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>C. Edgar S. Howard</b>   |   |   |  |



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

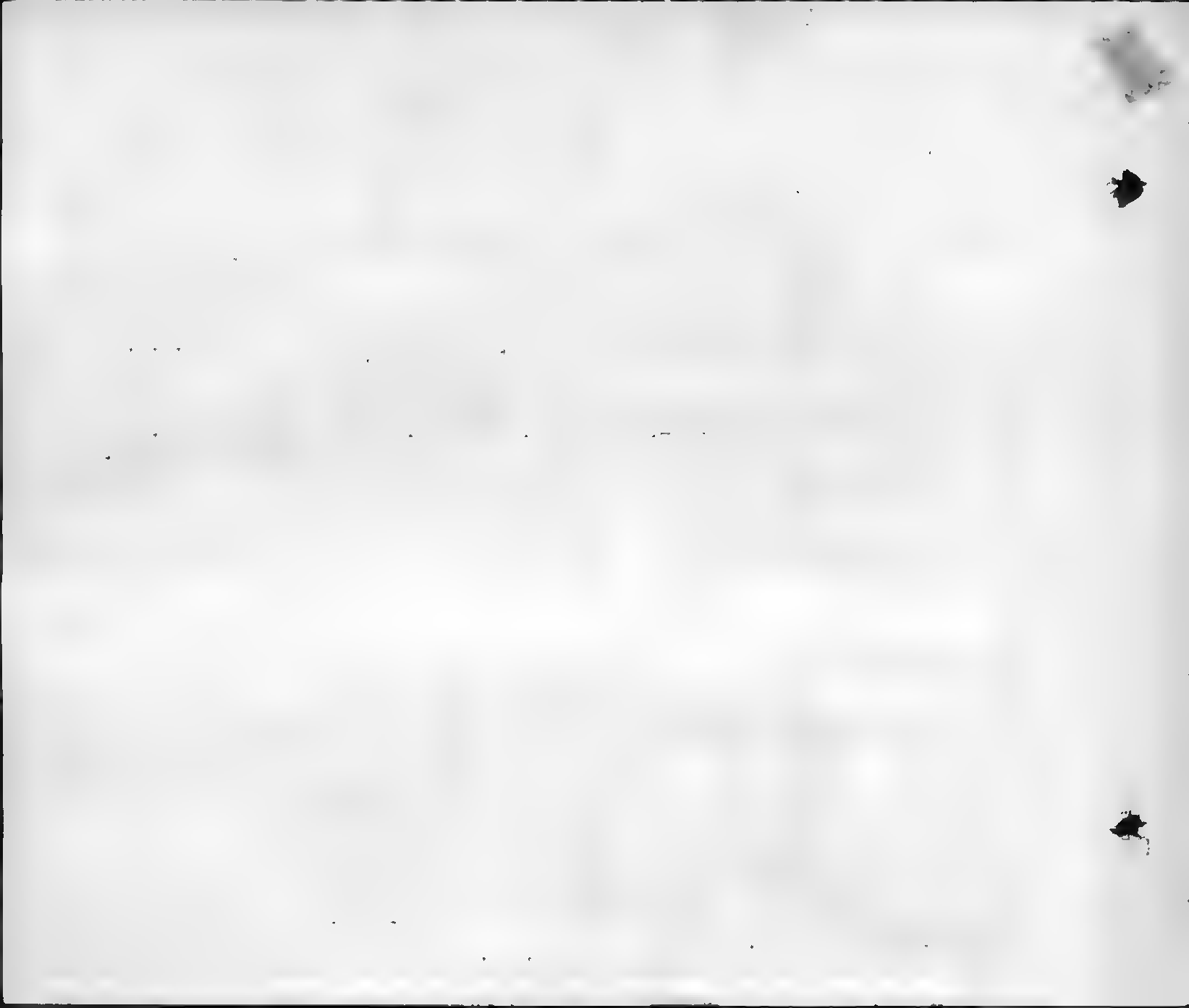
11570

## CERTIFICATE OF DEATH

Reg. Dist. No.

11561

|  |                                  |   |   |   |   |   |   |
|--|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FAIRLAND</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>6 days</b>                          |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BURTONSVILLE</b> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FAIRLAND NURSING HOME</b>   |                                  |   |   | d. STREET ADDRESS<br><b>BLACKBURN ROAD</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>CALEB ARTHUR SETZER</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>OCT. 2 19 58</b>   |   |   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/4/86</b>                                 |   | 9. AGE (In years lost birthday)<br><b>72</b> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min  | IF UNDER 24 HRS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Furniture Manufacturer</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Drexell Furniture Co.</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>                                      |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>Matthew Coleman Setzer</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Cynthia Elvira Moody</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>244-09-1552 A</b>  |   | 17. INFORMANT<br>Address<br><b>Mrs. Myrtle L. Setzer, Blackburn Rd. Burtonsville, Md.</b>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>33d x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>A. proplegia, thrombosis</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>1 Month</b>                                  |                                  |   |   |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>491X</b>   |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Jan 1, 1954</b> to <b>Oct 2, 1958</b> , that I last saw the deceased alive on <b>Oct 1, 1958</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>A. D. Bonifant</b> M.D. <b>Samuel S. Gray M.D.</b> <b>10/2/58</b><br>PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT</b> |                                  |   |   |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>10/5/58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BURTONSVILLE UNION CEMETERY</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MARYLAND</b>               |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WALTER E. PUMPHREY, INC.</b><br><b>Raymond A. Baska</b>   |                                  |   |   | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 6 '58</b>  |   |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kears</b>  |   |   |   |



11571

## CERTIFICATE OF DEATH

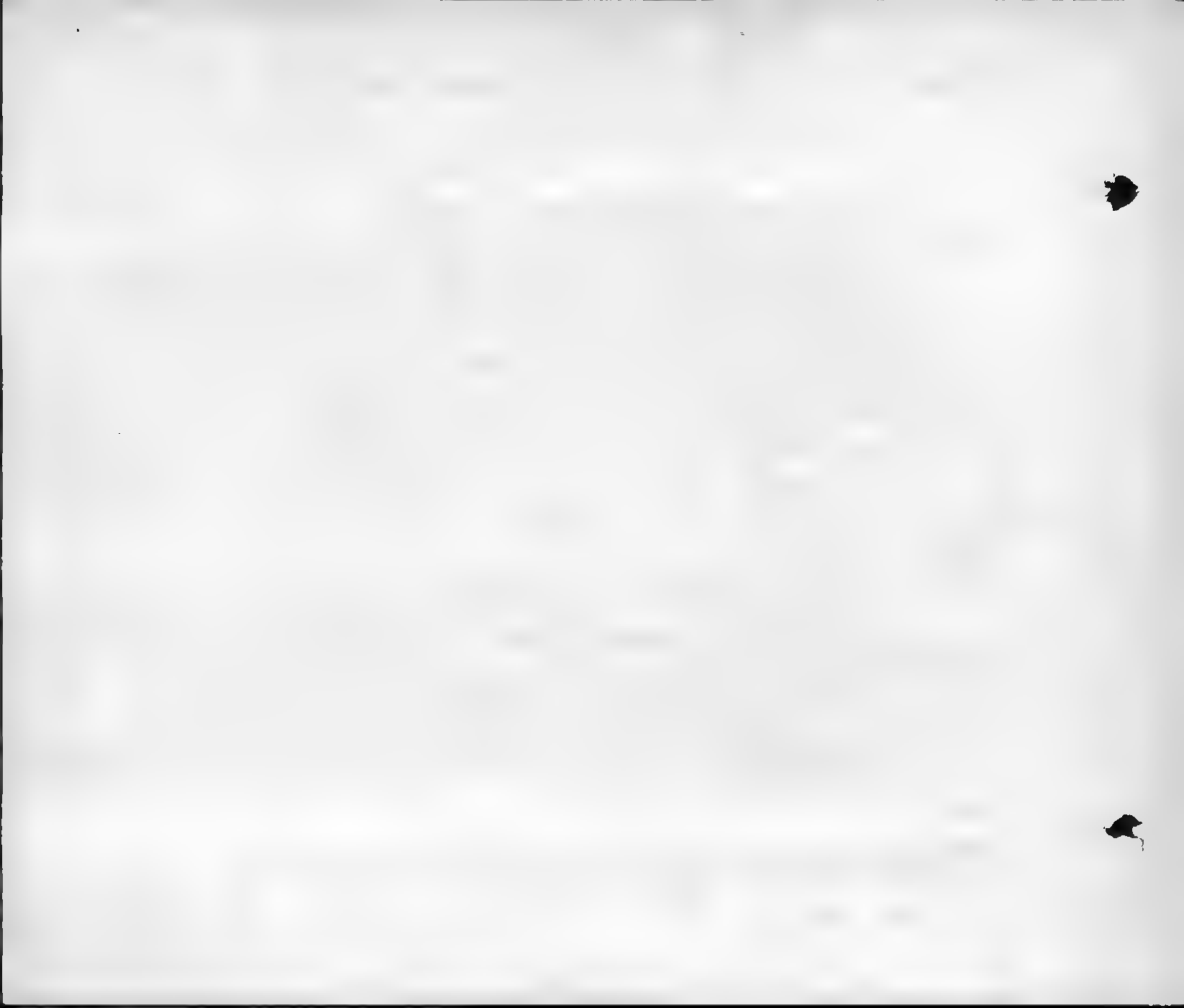
Reg. Dist. No.

11562

|  |                                   |  |  |  |   |   |  |
|--|-----------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o STATE <u>3342 - STUYVESANT PL. N.W.</u> b. COUNTY <u>WASHINGTON</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                                   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>   |   |   |  |
| c. LENGTH OF STAY IN 1b <u>6 hrs.</u>  |                                   |  |  | d. STREET ADDRESS <u>649</u>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP</u>  |                                   |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD LAWRENCE SHANKLE</u>   |                                   |  |  | 4. DATE OF DEATH Month Day Year <u>OCT. 27 1958</u>  |   |   |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WH.</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 16, 1883</u>                                  | 9. AGE (In years, last birthday) <u>74 yrs</u>   | 10. IF UNDER 1 YEAR: Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT.</u>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>BUREAU OF ENGINEERING</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>FREDRICK COUNTY MD</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>         |  |
| 13. FATHER'S NAME <u>MARTIN LUTHER SHANKLE</u>   |                                   |  |  | 14. MOTHER'S MAIDEN NAME <u>ANGLER RER</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>  |                                   | 16. SOCIAL SECURITY NO <u>NONE</u>   |  | 17. INFORMANT Address <u>DAUGHTER MRS GUTH RENARD - 3341 Stuyvesant</u>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MULTIPLE MYOCARDIAL INFARCTION</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROS</u><br>DUE TO (c) <u>HYPERTENSION</u>                    |                                   |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u><br><u>YEARS</u><br><u>YEARS</u>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>  |                                   |  |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <u>19</u>  | Month Day Year <u>1958</u>        | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <u>WASH. D.C.</u>  | (County)                                    | (State)   |  |
| 21. I certify that I attended the deceased from <u>Sept. 4, 1958</u> , to <u>Oct. 27, 1958</u> , that I last saw the deceased alive on <u>Oct. 27, 1958</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>2150 PA. AVE. N.W. WASH. D.C.</u> DATE SIGNED <u>Paul J. Taylor M.D.</u> |                                   |  |  |  |   |   |  |
| ACTUAL SIGNATURE <u>Paul J. Taylor M.D.</u> M.D. <u>2150 PA. AVE. N.W. WASH. D.C.</u>  |                                   |  |  |  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>PAUL N. TAYLOR M.D.</u>   |                                   |  |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>10/30/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Durham N.C.</u>   |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, Wash. D.C.</u> ADDRESS <u>510 3 WIS. AVE.</u>   |                                   |  |  | REC'D BY REGISTRAR <u>DATE OCT 30 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kious</u> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11563

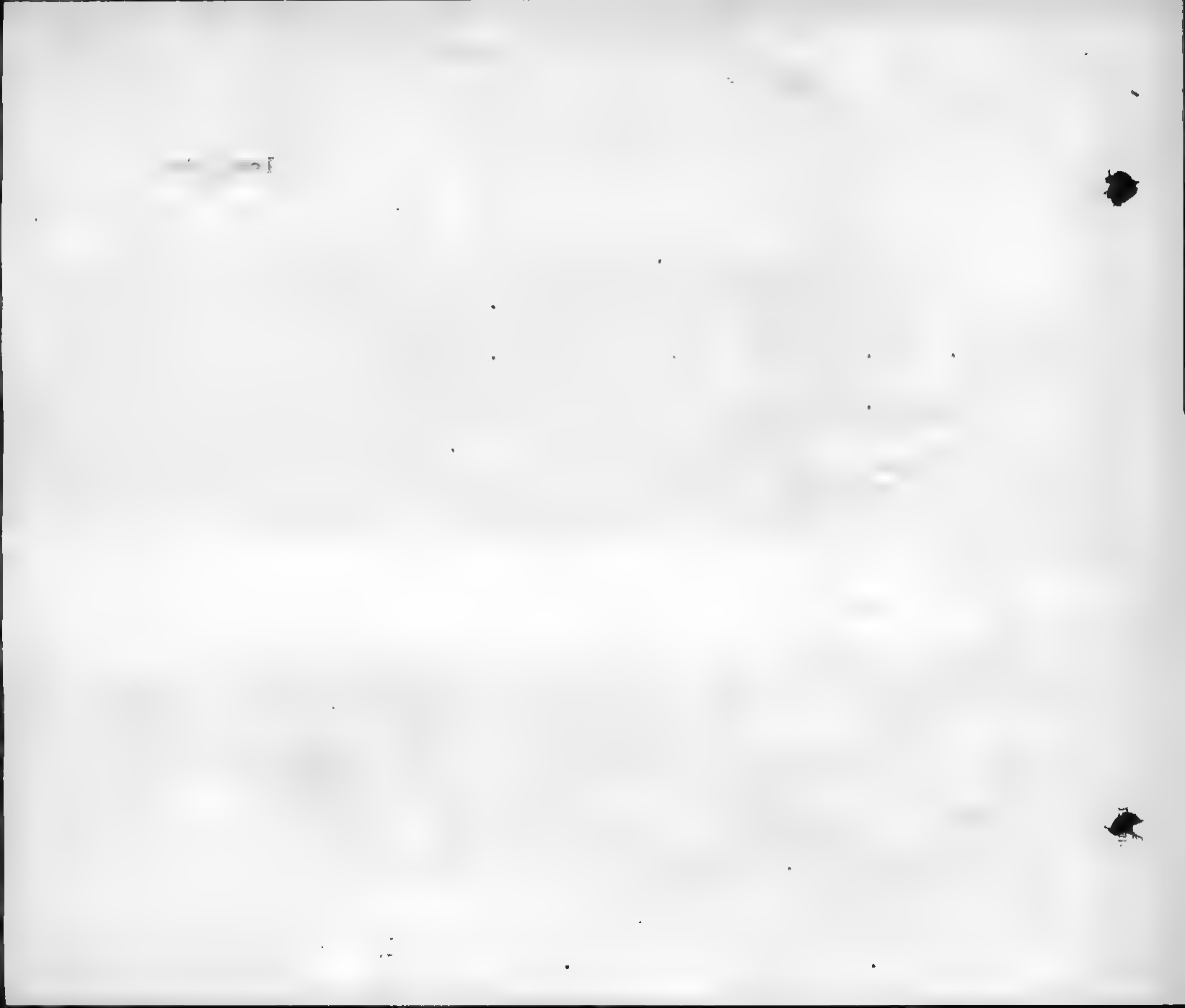
Reg. Dist. No.

11572

FOR STATE  
HEALTH DEPT.

|   |  |  |   |
|---|--|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>                                 |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fairway Hills *Glen Echo</u>  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fairway Hills -</u>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>6707 Larr Road</u>  |  | d STREET ADDRESS<br><u>6707 Larr Road</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>JOSEPH S. SHELLEY</u>  |  | 4 DATE OF DEATH<br>Oct. 4, 1958  |   |
| 5 SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>White</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 | 8 DATE OF BIRTH<br><u>Dec. 4, 1912</u>  |
| 9 AGE (In years last birthday)<br><u>45</u> yrs   |  | 10 IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>0</u> Hours <u>0</u>  |   |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ex. Secy.</u>  |  | 11b KIND OF BUSINESS OR INDUSTRY<br><u>Veg. Owners Assn. Pennsylvania</u>  |   |
| 12a BIRTHPLACE (State or foreign country)<br><u>US</u>  |  | 12b CITIZEN OF WHAT COUNTRY<br><u>US</u>   |   |
| 13 FATHER'S NAME<br><u>Robert L. Shelly</u>   |  | 14 MOTHER'S MAIDEN NAME<br><u>Hulga Siebert</u>  |   |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)   |  | 16 SOCIAL SECURITY NO<br><u>107-07-294</u>   |   |
| 17 INFORMANT<br><u>Edith R. Shelly-Item</u>   |  | Address<br><u>7</u>  |   |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)   |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE<br><u>Frank J. Broschart</u>   |  | DATE SIGNED<br><u>10/4/58</u>  |   |
| EXAMINER'S NAME (Type)<br><u>Frank J. Broschart</u>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |
| 22a. BURIAL CREMATION REMOVAL (Specify)<br><u>Bur-transit</u>   | 22b DATE THEREOF<br><u>10/8/58</u>   | 22c NAME OF CEMETERY OR CREMATORY<br><u>Riverview</u>  | 22d LOCATION (City, town, or county) (State)<br><u>Huntingdon, Pennsylvania</u> |
| 23 FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-Bethe</u>  |  | 24a REC'D BY REGISTRAR<br>DATE <u>OCT 7 '58</u>  |   |
|   |  | 24b REGISTRAR'S SIGNATURE<br><u>Arthur S. Kneel</u>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11564

Reg. Dist. No. 215

11573

|  |                                  |   |                                   |   |   |
|--|----------------------------------|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  | MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY |   |
| c. LENGTH OF STAY IN TB<br><b>72 days</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>Washington</b>   |                                   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>U. S. Naval Hospital</b>   |                                  | d. STREET ADDRESS<br><b>1616 16th Street, N.W.</b>  |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Roy</b>  |                                  | First<br><b>"A"</b><br>Middle<br><b>SLACK</b><br>Last   |                                   | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>8</b><br>Year<br><b>1958</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-5-89</b> |   | 9. AGE (In years last birthday) yrs<br><b>69</b>      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>George SLACK</b>  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Josephine BLACK</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes</b> <b>WWI</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Not known</b>   |                                   | 17. INFORMANT<br><b>Son, Paul D. Slack, same as item #2 above</b><br>Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>162.1</b><br><b>Bronchogenic carcinoma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)<br>DUE TO (c) |                                  |   |                                   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4-6 months</b> |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>U. S. Naval Hospital, NNMC</b>                                 |   |
| 20f. (City or town)<br><b>Bethesda</b>   |                                  | 20g. (County)<br><b>Montgomery</b>  |                                   | 20h. (State)<br><b>Maryland</b>   |   |
| 21. I certify that I attended the deceased from <b>July 29</b> , 19 <b>58</b> , to <b>October 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>October 7</b> , 19 <b>58</b> , and that death occurred at <b>3:30A</b> M, from the causes and on the date stated above.                      |                                  |   |                                   |   |   |
| ACTUAL SIGNATURE<br><b>E. J. Rupnik</b>  |                                  | M D<br><b>U. S. Naval Hospital, NNMC</b>  |                                   | DATE SIGNED<br><b>10-8-58</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>E. J. RUPNIK LCDR MC USN</b>   |                                  | ADDRESS<br><b>Bethesda 14, Maryland</b>   |                                   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-10-58</b>  |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |   |
| 22d. LOCATION (City, town, or county)<br><b>Arlington</b>  |                                  | 22e. (State)<br><b>Virginia</b>   |                                   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. W. Chambers</b>  |                                  | ADDRESS<br><b>1400 Chapin St., NW, Washington, D.C.</b>   |                                   | 24a. REC'D BY REGISTRAR<br><b>Oct 10 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |   |                                   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

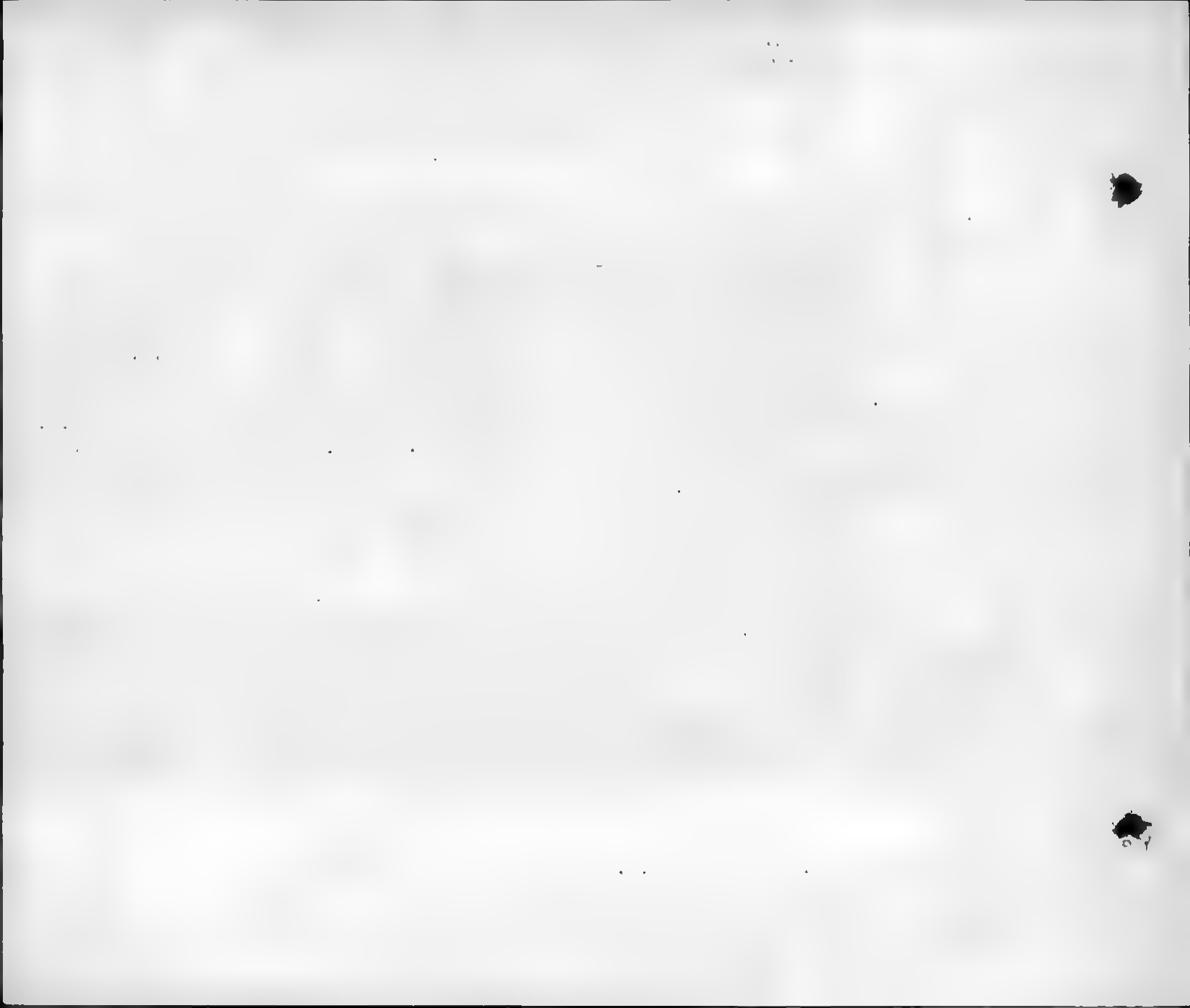
11574

11565

Reg. Dist. No.

|   |                                  |   |                                   |   |  |   |                                  |
|---|----------------------------------|---|-----------------------------------|---|--|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>82 days</u>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |  |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>U. S. Naval Hospital</u>   |                                  |   |                                   | d. STREET ADDRESS<br><u>Emory Lane</u>  |  | e. IS RESIDENT ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Charles Henry SMITH</u>  |                                  |   |                                   | 4. DATE OF DEATH<br>Month Day Year<br><u>October 7 1958</u>   |  |   |                                  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-2-94</u> |   | 9. AGE (in years last birthday)<br><u>64</u> yrs | 10. IF UNDER 1 YEAR<br>Months Days  | 11. IF UNDER 24 HRS<br>Hours M n |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Construction</u>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME<br><u>Benjamin F. SMITH</u>   |                                  |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Elizabeth Betty LUCAS</u>   |  |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br><u>WWI</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>Not known</u>   |                                   | 17. INFORMANT<br><u>(Sister) Mrs. Emma Tanner, 3101 Sherman Ave., NE</u>  |  |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Right pneumonectomy procedure</u><br>DUE TO<br>(c) _____  |                                  |   |                                   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>7 1/2 hours</u>                           |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Carcinoma right lung</u>  |                                  |   |                                   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                   |   |  |   |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |                                  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                   |   |  |   |                                  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |                                  |   |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED   |                                  |
| EXAMINER'S NAME (Type) <u>Frank J. BROSCART, M.D.</u>   |                                  |   |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | 10-8-58   |                                  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  |   |                                   |   |  |   |                                  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 22b. DATE THEREOF<br><u>10-10-58</u>  |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Arlington Virginia</u>                        |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert Snowden</u><br>ADDRESS<br><u>Rockville, Maryland</u>  |                                  |   |                                   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 16 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Evans</u>  |                                  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11575

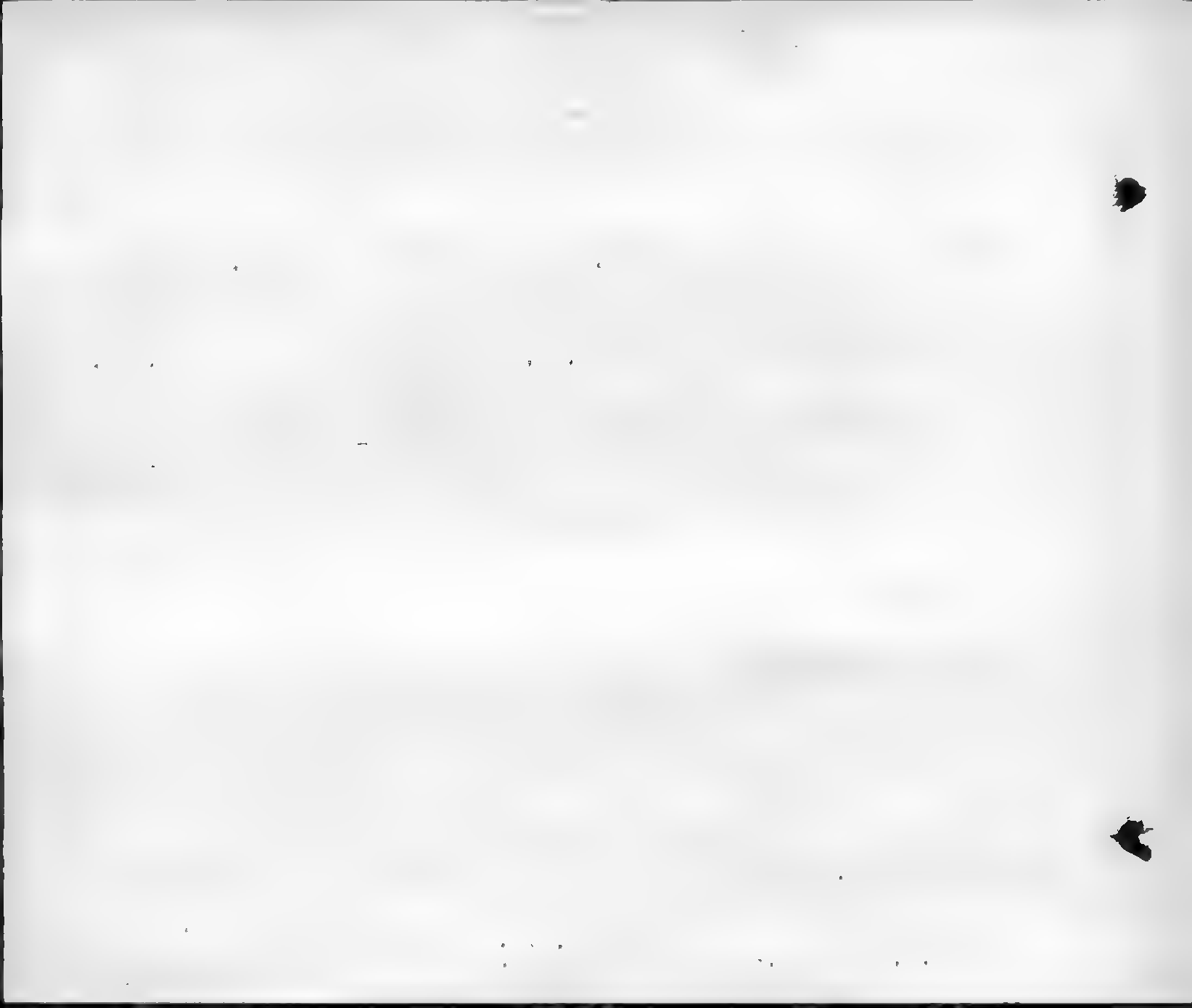
CERTIFICATE OF DEATH

11566

Reg. Dist. No.

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>420 Mansfield Road</b>  |                                      | d. STREET ADDRESS<br><b>420 Mansfield Road</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hazel</b> Middle <b>K.</b> Last <b>Smith</b>   |                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>16,</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/17/1881</b>                                     |
| 9. AGE (In years last birthday) <b>77</b> yrs.   |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary- Retired</b>                                  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Michigan</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Frank C. Smith</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Walbridge</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>577-22-2121</b>  |  |
| 17. INFORMANT<br><b>Virginia Smith</b>   |                                      | Address<br><b>420 Mansfield Road Silver Spring, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>Myocarditis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <b>Hypertension</b><br>DUE TO<br>(c). <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b><br><b>15 yrs.</b><br><b>10 yrs.</b>  |                                      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |                                      |  |  |
| 21. I certify that I attended the deceased from <b>1948</b> , 19____, to <b>Oct. 16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct. 10</b> , 19 <b>58</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>13016 Georgia Ave. Silver Spring, Md.</b><br>DATE SIGNED <b>10/16/58</b><br>ACTUAL SIGNATURE <b>A.W. Smith, M.D.</b><br>PHYSICIAN'S NAME (Type) <b>A.W. Smith</b>   |                                      |  |  |
| 22a. BURIAL, CREMATION, or other (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/18/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Mines Co.-2901 14th St., N.W.</b>  |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 17 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Colburn S. Kraus</b>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11576

## CERTIFICATE OF DEATH

11567

Reg. Dist. No.

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                      | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Hall Sanatorium</b>  |                                      | d STREET ADDRESS<br><b>3945 Conn. Ave. N. W.</b>   |  |
| 3 NAME OF DECEASED (Type or print) First Middle Last<br><b>Mamie E. Smith</b>   |                                      | 4. DATE OF DEATH Month Day Year<br><b>Oct 9 1958</b>   |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b>            | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug 23, 1883</b>                                    |
| 9 AGE (In years last birthday) <b>75</b> yrs.   |                                      | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>John Hesser</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Climenti Sitcitt</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                      | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mrs. Edna Grammond-3024 Tilden St. N.W.</b>   |                                      | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO (c) |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs.</b><br><b>5-6 gm.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 10, 1942</b> to <b>Oct 9, 1958</b> , that I last saw the deceased alive on <b>Oct 9, 1958</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.  |                                      |  |  |
| ACTUAL SIGNATURE <b>W. B. Wardrop</b> M.D.  |                                      | ADDRESS (Street, city or town, State) <b>837 Bonifant St.</b> DATE SIGNED <b>10/9/58</b>   |  |
| PHYSICIAN'S NAME (Type) <b>W. B. WARDROP, M.D.</b>  |                                      | <b>837 BONIFANT ST. SILVER SPRING, MD.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/13/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hamilton, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. H. Hines Co. Washington, D. C.</b>  |                                      | 24a. REC'D BY REGISTRAR<br><b>OCT 14 58</b> DATE   |  |
|   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |  |





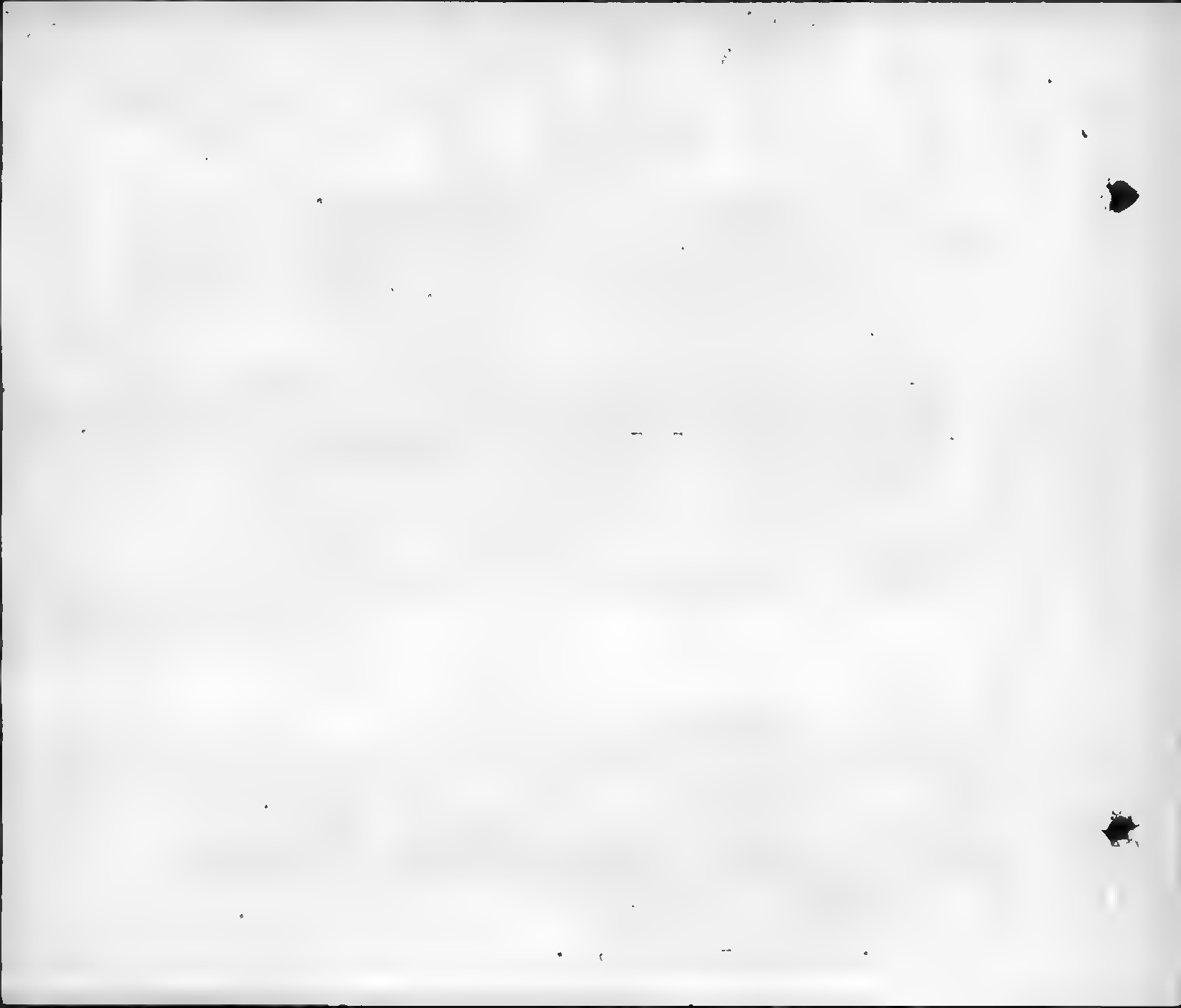
11577

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                            |   |   |   |  |  |                                      |
|---|----------------------------|---|---|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                            |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |                            |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |  |  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>4822 Morgan Drive</b>   |                            |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                                      |
| 3. NAME OF DECEASED (Type or print)<br><b>Martha Jane Smith</b>   |                            |   |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>10</b> Year <b>1958</b>  |  |  |                                      |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>CW</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 6, 1983</b>  |   | 9. AGE (In years last birthday) <b>75</b> yrs.                         | IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                            | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 13. FATHER'S NAME<br><b>Sion David Williams</b>   |                            |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Georgiana Atkinson</b>   |  |  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>  |                            | 16. SOCIAL SECURITY NO.<br><b>242-16-2140B</b>  |   | 17. INFORMANT<br><b>Margaret S Williams (Daughter)</b>  |  | Address <b>4822 Morgan Dr Chevy Chase, Md</b>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia &amp; pneumonia</b><br>DUE TO <b>Emaciation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Squamous cell carcinoma, primary site, mouth</b><br>(c) <b>1-2 years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>36 hrs</b><br><b>3 weeks</b> |                            |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b><br><b>3 weeks</b>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            |   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                                      |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a. m. p. m. <b>19</b>   |                            |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>October 10, 1958</b> , that I last saw the deceased alive on <b>Oct. 9, 1958</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4630 Montgomery Ave., Bethesda, Md</b> DATE SIGNED <b>10/10/58</b>  |                            |   |   |   |  |  |                                      |
| ACTUAL SIGNATURE <b>Robert H Goale</b>  |                            |   |   | PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE M.D. 4630 MONTGOMERY AVE. BETHESDA MD</b>  |  |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-Transit 10/13/58</b>  |                            | 22b. DATE THEREOF<br><b>10/13/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oakwood</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Raleigh, N. Carolina</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>   |                            |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11578

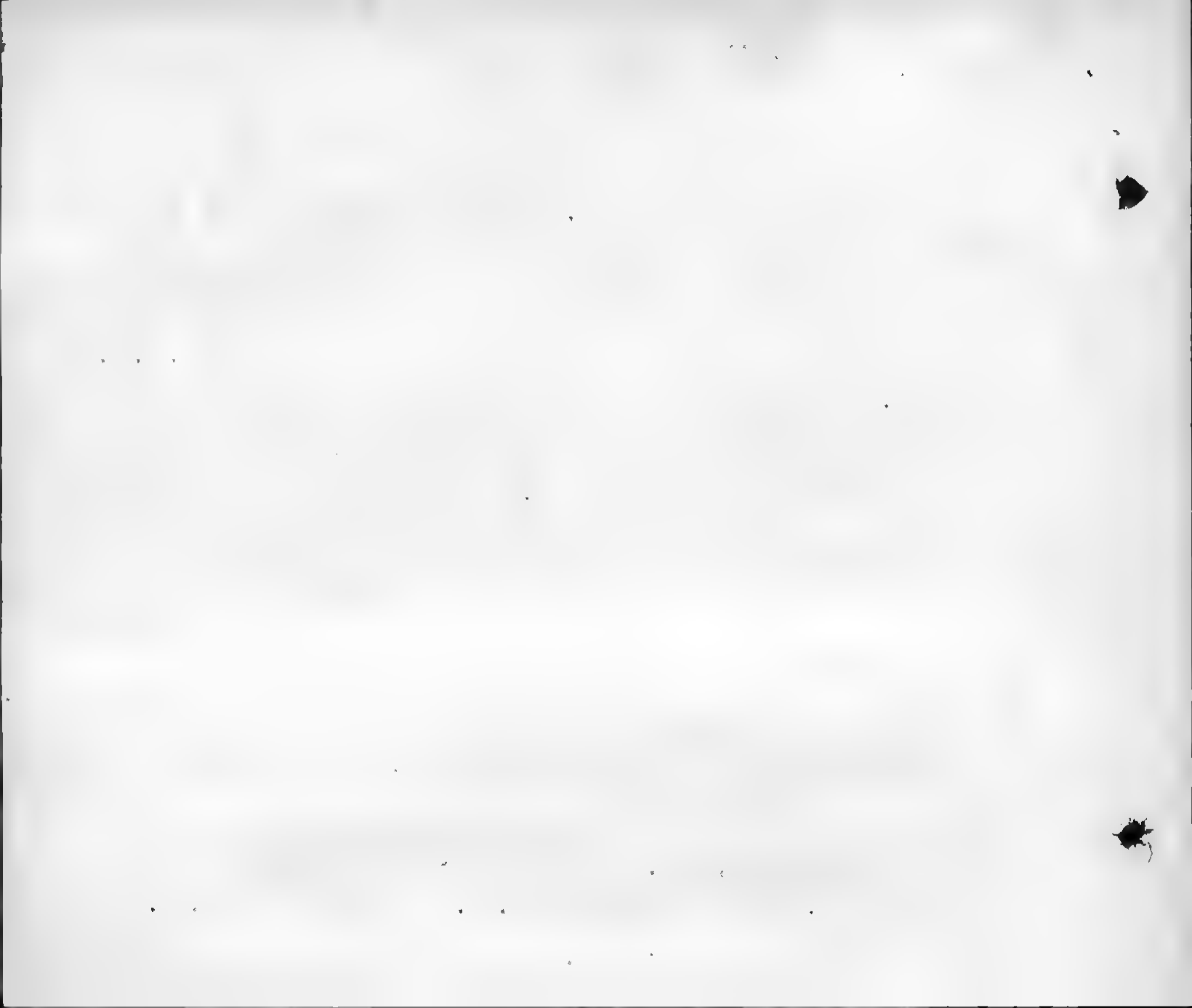
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><u>West Virginia</u><br>b. COUNTY                      |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY in 1b<br><u>35 days</u>    |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Morgantown</u>   |  |   |  |
| d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION<br><u>The Clinical Center, Bethesda 14, Md.</u>  |  |  |  | d. STREET ADDRESS<br><u>117 Arch Street</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Mary</u> Middle <u>Margaret</u> Last <u>Smith</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>16</u> Year <u>1958</u>   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>October 5, 1956</u>  |  |
| 9. AGE (in years last birthday) yrs<br><u>2</u>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min |  | 11. BIRTHPLACE (State or foreign country)<br><u>Peru</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Child</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Peru</u>  |  |
| 13. FATHER'S NAME<br><u>Freeman P. Smith</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Rose Pilegge</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>       |  | 17. INFORMANT<br><u>The Medical Record</u> Address<br><u>The Clinical Center, Bethesda 14, Maryland</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |   |  |   |  |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Suppurative Meningitis (pneumococcal)</u>   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u>  |  |
| 2043 DUE TO   |  |  |  |   |  |   |  |
| Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |  |   |  |
| (b) <u>Acute Lymphocytic Leukemia</u>   |  |  |  |   |  |   |  |
| DUE TO  |  |  |  |   |  |   |  |
| (c)   |  |  |  |   |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)   |  |  |  | 20g. (County)   |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <u>September 11, 1958</u> , to <u>October 16, 1958</u> , that I last saw the deceased alive on <u>October 16, 1958</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above |  |  |  |   |  |   |  |
| ADDRESS (Street, city or town, state)<br><u>The Clinical Center</u>   |  |  |  | DATE SIGNED<br><u>10/16/58</u>  |  |   |  |
| ACTUAL SIGNATURE<br><u>Leonard Garren</u> M.D.  |  |  |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>Leonard Garren, M. D.</u>   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF<br><u>Oct. 19, 1958</u>    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Morgantown, W. Va.</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Morgantown, W. Va.</u>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |  |  |  | ADDRESS<br><u>Bethesda, Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 20 '58</u>   |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kross</u>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

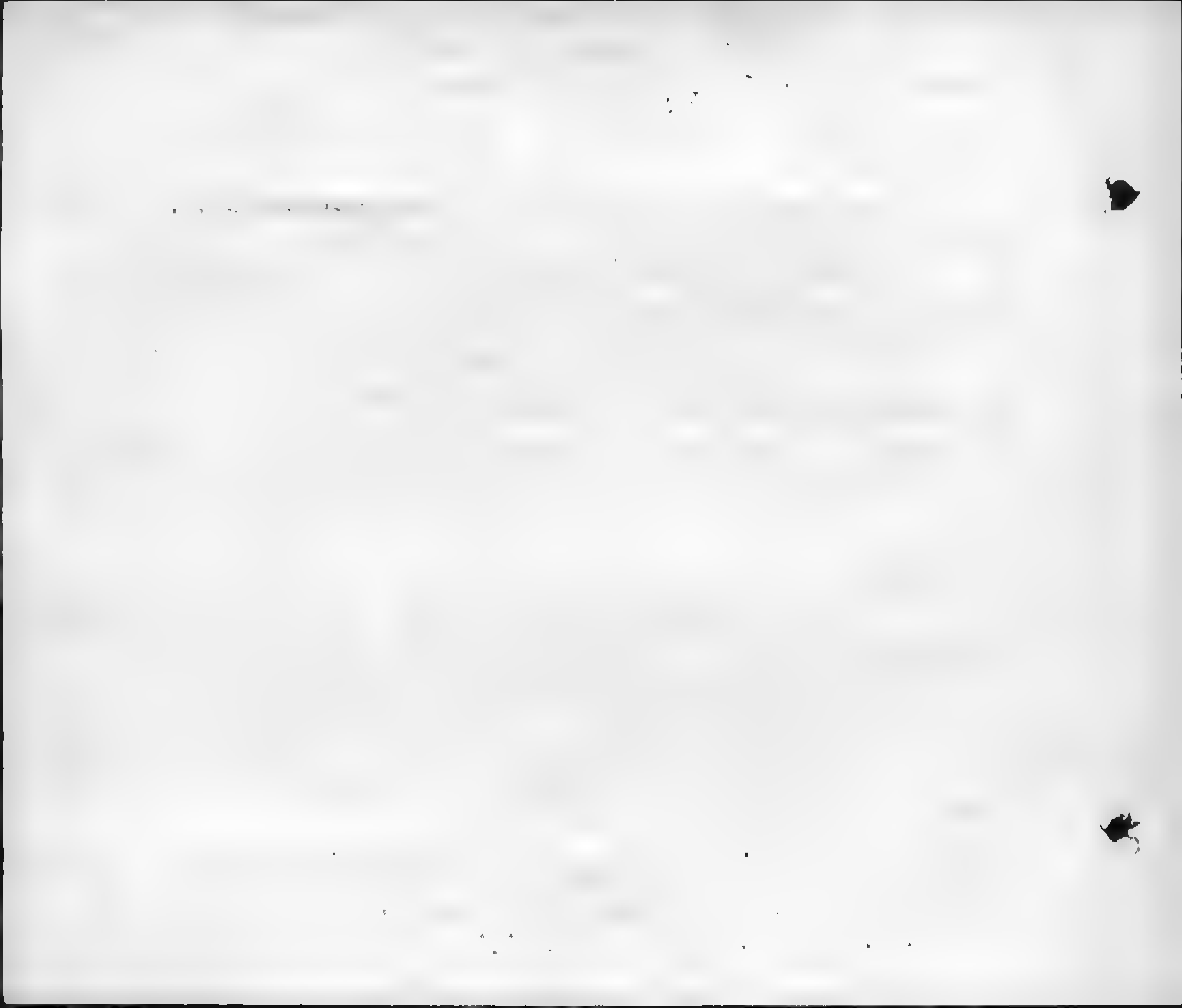


Reg. Dist. No.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>District of Columbia</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  | c. LENGTH OF STAY IN TB<br><b>37 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>Washington 47X-</b>                     |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>1405 Somerset Place, N.W.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><b>Myrtle</b>  |  | Last<br><b>Smith</b>   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 4. DATE OF DEATH<br>Month<br><b>October</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>4/16/86</b>  |  | Day<br><b>7,</b>   |  |
| 9. AGE (In years last birthday) yrs<br><b>72</b>  |  | IF UNDER 1 YEAR<br>Months<br><b>12</b>  |  | Year<br><b>1958</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>FRANKLIN SUDDATH</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA HOBBS</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. Louis F. Napoli</b>   |  |
| Address<br><b>10 Grandin Circle</b>   |  | Rockville, Md.  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary failure - very thrombosed</b>   |  |   |  |  |  |
| DUE TO (b) <b>C.H.F.</b>  |  |   |  |  |  |
| DUE TO (c) <b>C-S. 14 thrombosis</b>  |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b>  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>          |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town)   |  | (County)  |  | (State)  |  |
| 21. I certify that I attended the deceased from <b>8/31, 1957</b> , to <b>10/7, 1958</b> , that I last saw the deceased alive on <b>10/7, 1958</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above. |  |   |  |  |  |
| ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>10/7/58</b>  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Stephen N. Jones</b>   |  | PHYSICIAN'S NAME (Type)<br><b>Stephen N. Jones</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10/10/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem. Arlington, Virginia</b>   |  |
| 22d. LOCATION (City, town, or county)   |  | (State)   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. Hines Co. 2901 14th St., N.W.</b>   |  | ADDRESS<br><b>Wash. D.C.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>OCT 10 58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |  |   |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11571

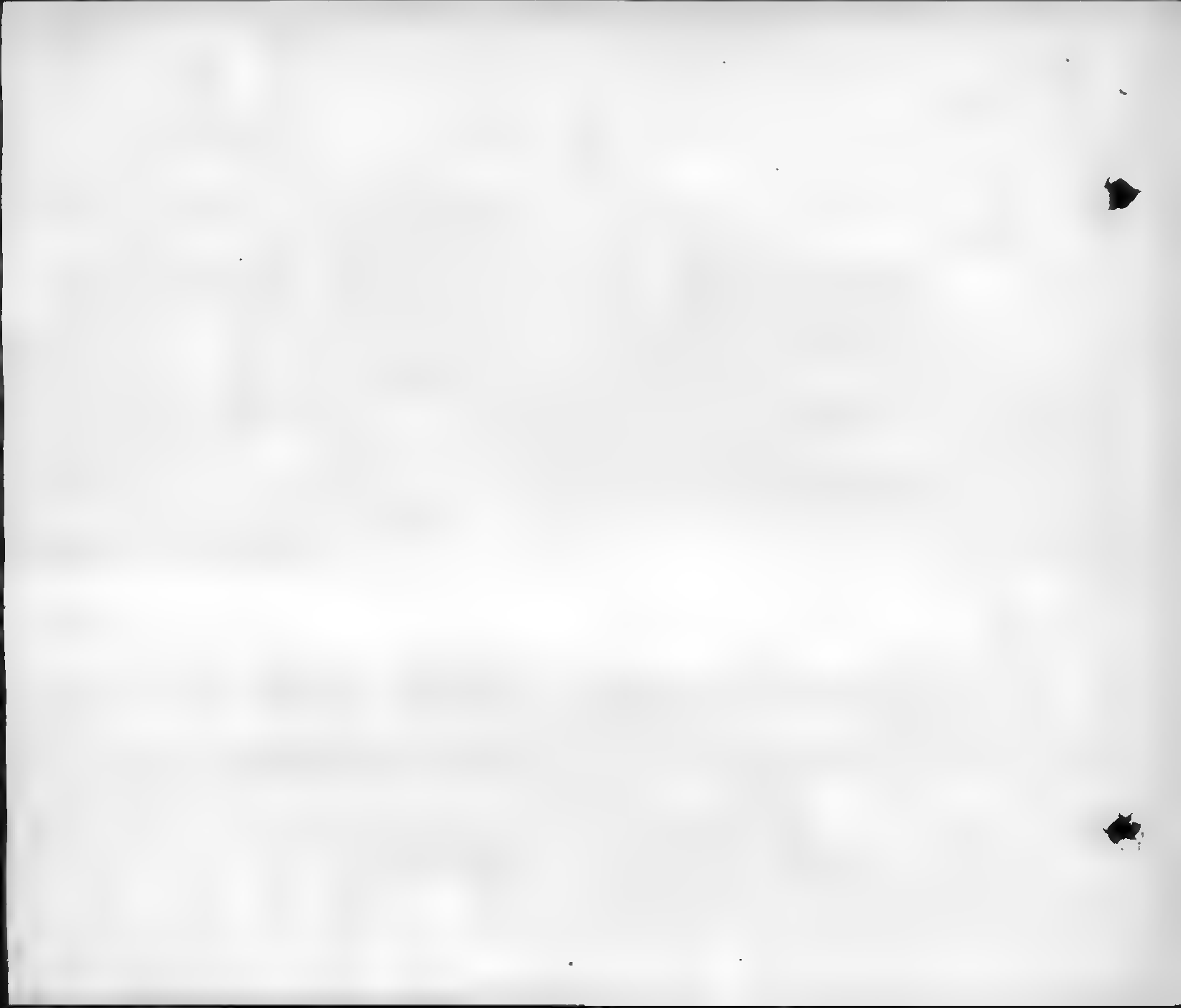
FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

|  |  |  |                                      |
|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Monty</u>                        |                                      |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>   |  | c. LENGTH OF STAY IN 1b <u>3 yr</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5930 LeMay Rd</u>  |  | e. STREET ADDRESS <u>15930 LeMay Rd</u>  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Ralph Carter Spaulding</u>  |  | 4. DATE OF DEATH <u>Oct 23 1958</u>  |                                      |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-26-1900</u>    |
| 9. AGE (In years last birthday) <u>58</u> yrs  |  | 10. IF UNDER 1 YEAR Months Days Hours M n  |                                      |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt U.S.N.</u>  |  | 12. KIND OF BUSINESS OR INDUSTRY <u>retired</u>  |                                      |
| 13. BIRTHPLACE (State or foreign country) <u>Mass</u>  |  | 14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |                                      |
| 15. FATHER'S NAME <u>Carter Spaulding</u>  |  | 16. MOTHER'S MAIDEN NAME <u>Louise Baker</u>   |                                      |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)   |  | 18. SOCIAL SECURITY NO   |                                      |
| 19. INFORMANT <u>Barbara Spaulding</u>   |  | Address <u>Stuen 2</u>   |                                      |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |                                      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO<br>(c) _____  |  |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |  |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |                                      |
| ACTUAL SIGNATURE <u>Frank J. Broschiant</u> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschiant</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                      |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>10/27/58</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>OCT 27 '58</u>  |                                      |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>John E. Lewis</u>  |                                      |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Seal of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.





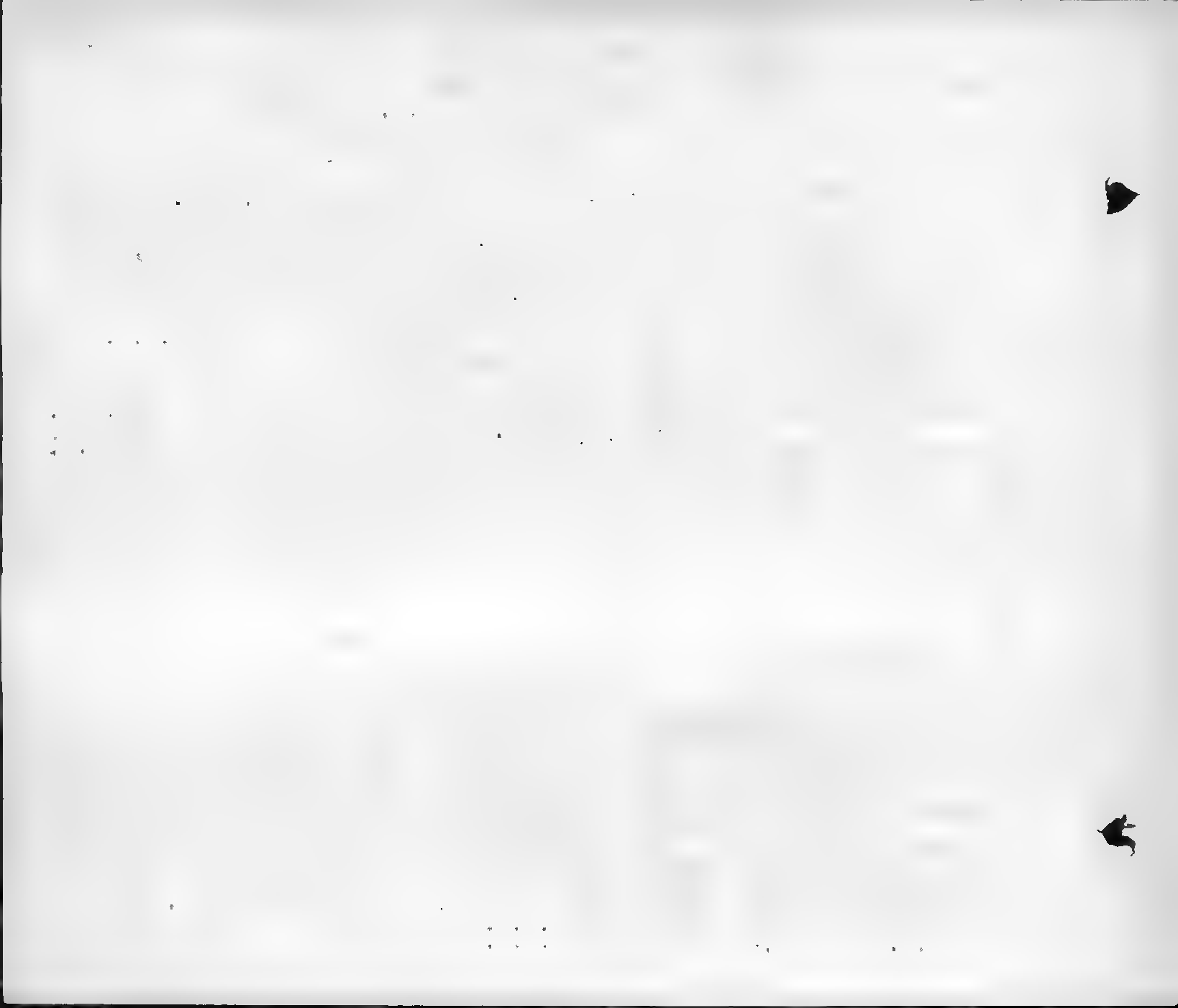
11460

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY                                     |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington,</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington Sanitarium</b>   |                                  | d. STREET ADDRESS<br><b>5603 Georgia Ave., N.W.</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Martin</b> Middle <b>Sproger</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>1958</b>   |                                       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/10/1895</b> |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Indrikis Sproger</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ilze -</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>060-10-9348</b>   |                                       |
| 17. INFORMANT<br><b>Mrs. Laura Sproger</b>   |                                  | Address <b>Wash. D.C. 5603 Georgia Ave., N.W.</b>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).<br><b>401A</b> DUE TO <b>Cardiac Tamponade</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DISSECTING AORTIC ANEURYSM</b><br>(c) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 HOURS</b><br><b>18 HOURS</b><br><b>8 YEARS</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)  |                                       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>July 1955</b> to <b>Oct 24 1958</b> that I last saw the deceased alive on <b>Oct 23, 1958</b> and that death occurred at <b>1:55 PM, 10/24/58</b> from the causes and on the date stated above.   |                                  |   |                                       |
| ACTUAL SIGNATURE<br><b>Robert L. Krichmar</b>  |                                  | ADDRESS (Street, city or town, state) <b>7733 ALASKA AVE., WASH DC</b>  |                                       |
| PHYSICIAN'S NAME (Type)<br><b>ROBERT L. KRICHMAR</b>   |                                  | DATE SIGNED<br><b>OCT 24 1958</b>   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10/27/58</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.-2901</b>   |                                  | ADDRESS <b>Wash. D.C. 14th St., N.W.</b>  |                                       |
| 24a. REC'D BY REGISTRAR<br><b>OCT 27 1958</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Curtis S. Kline</b>  |                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11573

Reg. Dist. No.

11580

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |  | e. STREET ADDRESS <u>2712 Wisconsin Ave.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>B.</u> Last <u>Sprouse</u>   |  | 4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1958</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>May 2 1902</u> 9. AGE (In years last birthday) <u>56</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Government</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Georgia</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>James H. Sprouse</u>  |  | 14. MOTHER'S MAIDEN NAME <u>William B. Sprouse</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO <u>20-32 3150</u>   |  |
| 17. INFORMANT <u>William B. Sprouse</u> Address <u>2000 BATHING Ave</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intra-Cardiac Thrombosis, Right</u><br>DUE TO <u>Simultaneous Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Obstructive Coronary Arteriosclerotic Heart Disease</u><br>DUE TO <u>Obstructive Coronary Arteriosclerotic Heart Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u><br><u>Unknown</u><br><u>Unknown</u>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEERT</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-27-58</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>10-27-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Longwood Cem</u>   | 22d. LOCATION (City, town, or county) (State) <u>Abbeville So Carolina</u>       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>  |  | 24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>   |  |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>Caroline S. Thomas</u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11468

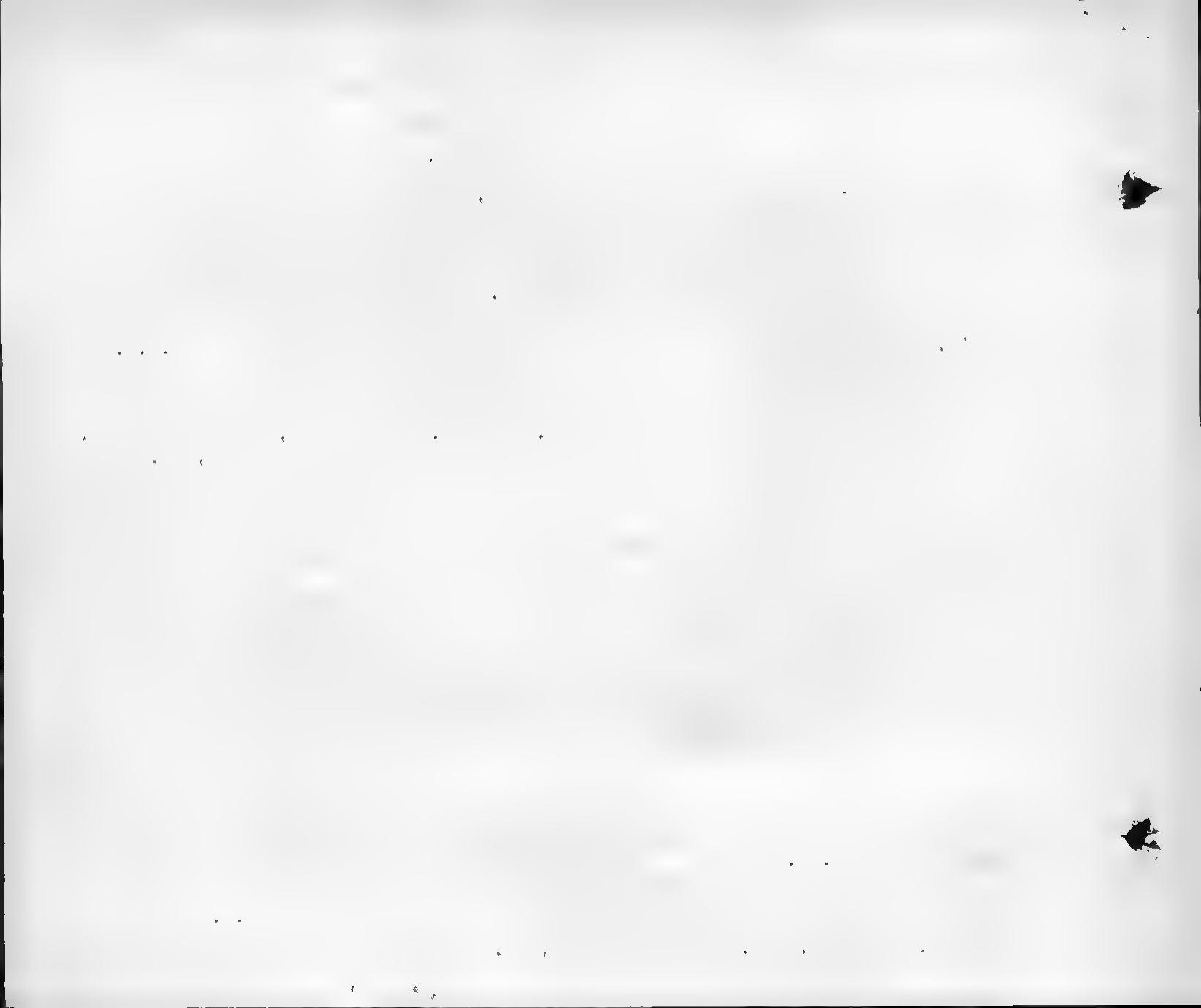
## CERTIFICATE OF DEATH

11574

Reg. Dist. No.

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                                 | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a STATE <b>MARYLAND</b> b COUNTY <b>MONTGOMERY</b>                   |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b>   |   |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15,015 Rosecroft Road</b>  |                                 | d STREET ADDRESS<br><b>15,015 Rosecroft Road</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>CLARENCE</b> Middle <b>THOMAS</b> Last <b>STEWART</b>  |                                 | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>27</b> Year <b>19 58</b>   |   |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>Oct. 12, 1875</b> |
| 9 AGE (In years last birthday)<br><b>83</b> yrs.  |                                 | IF UNDER 1 YEAR<br>Months Days Hours Min   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Sup't. of Pullman Company</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MARYLAND</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>WILLIAM STEEN STEWART</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>ANN ZIPPORAH WARREN</b>   |   |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO XXXX</b>  |                                 | 16 SOCIAL SECURITY NO.<br><b>YES</b>   |   |
| 17 INFORMANT<br><b>Mrs. Agnes H. Stewart, 15,015 Rosecroft Rd. Rockville, Md.</b>   |                                 | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Uraemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <b>Chronic Nephritis</b><br>(c) <b>Arterio Sclerosis</b>  |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 day</b><br><b>4 years</b><br><b>4 years</b>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>7/1</b> 19 <b>58</b> to <b>10/28</b> 19 <b>58</b> that I last saw the deceased alive on <b>10-28</b> 19 <b>58</b> and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>SIGNATURE <b>J. W. Bird</b> M.D. <b>Sandy S. M.</b><br>PHYSICIAN'S NAME (Type) <b>J. W. BIRD</b> |                                 |  |   |
| 22a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 22b DATE THEREOF<br><b>10/30/58</b>  |   |
| 22c NAME OF CEMETERY OR CREMATORY<br><b>ROCK CREEK CEMETERY</b>   |                                 | 22d LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>  |   |
| 23 FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Gloska</b>  |                                 | 24a REC'D BY REGISTRAR<br><b>OK 29 58</b><br>DATE  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>C. J. S. M.</b>  |                                 |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11581

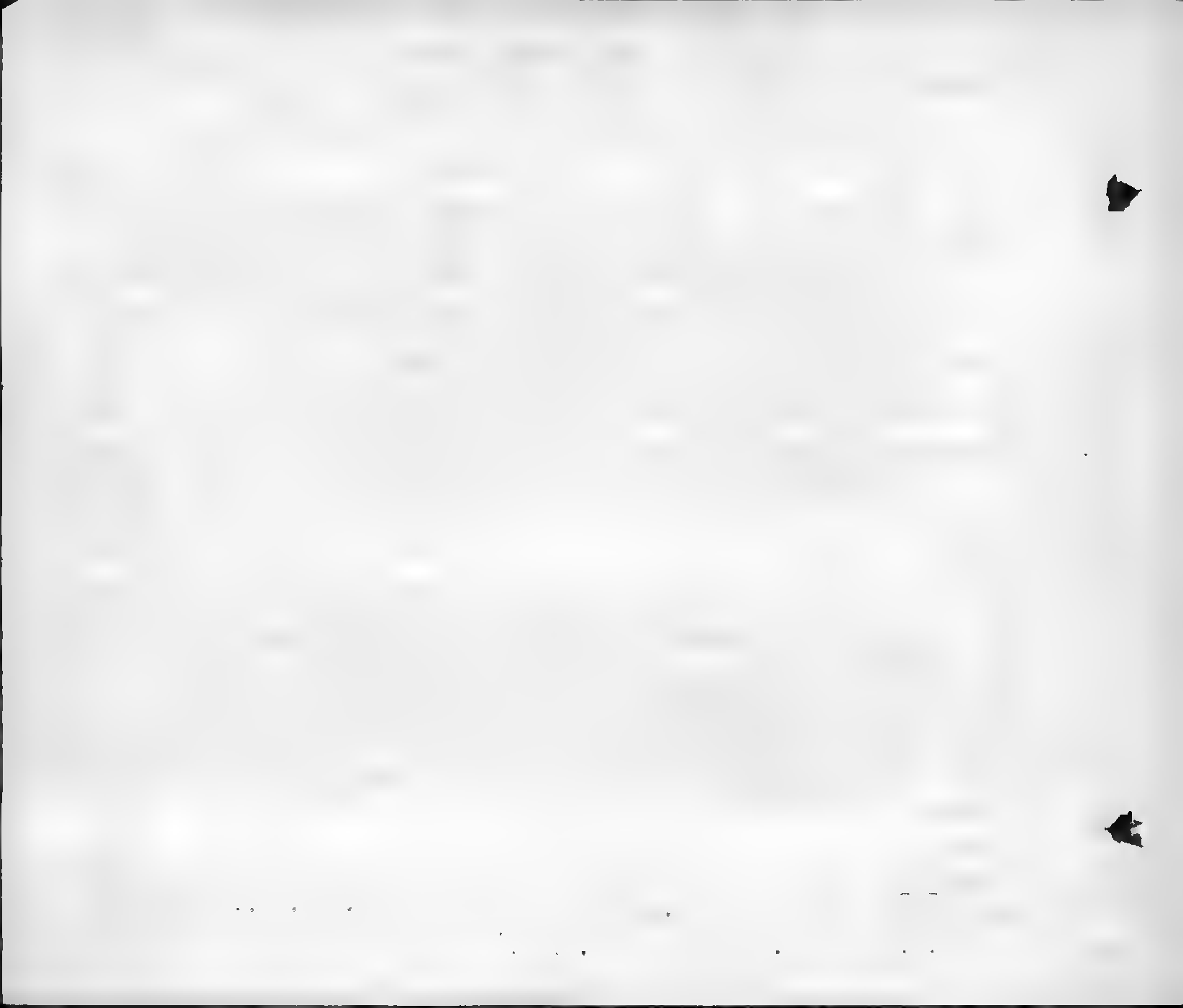
CERTIFICATE OF DEATH

11575

Reg. Dist. No.

|   |                           |  |                                   |   |                                     |   |  |
|---|---------------------------|--|-----------------------------------|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           |  |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY |                                     |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>   |                           |  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>                               |                                     |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>   |                           |  |                                   | d. STREET ADDRESS <u>1</u>  |                                     |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Marion R. Strickling</u>   |                           |  |                                   | 4. DATE OF DEATH <u>Oct. 20 1958</u>  |                                     |   |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-13-1865</u> | 9. AGE (In years last birthday) <u>93 yrs.</u>  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                                   | 11. BIRTHPLACE (State or foreign country) <u>Scranton Pa</u>  |                                     | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                  |  |
| 13. FATHER'S NAME <u>David Richards</u>   |                           |  |                                   | 14. MOTHER'S MAIDEN NAME <u>Mary Williams</u>   |                                     |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or date of service)  |                           | 16. SOCIAL SECURITY NO. <u>—</u>   |                                   | 17. INFORMANT <u>Hospital Records &amp; Son</u> Address   |                                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsisemia</u><br>538X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subacute Angina</u><br>DUE TO<br>(c)   |                           |  |                                   |   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>6 days</u>          |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                   |   |                                     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                           |  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)                                 |                                     |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19 <u>58</u>   |                           |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
|   |                           |  |                                   | 20f. (City or town) (County) (State)  |                                     |   |  |
| 21. I certify that I attended the deceased from <u>Aug. 1955</u> to <u>Oct. 20, 1958</u> , that I last saw the deceased alive on <u>Oct. 17, 1958</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Sandy Springs, Maryland</u> DATE SIGNED <u>10/20/58</u> |                           |  |                                   |   |                                     |   |  |
| ACTUAL SIGNATURE <u>J.W. Bird</u> M.D.  |                           |  |                                   | PHYSICIAN'S NAME (Type) <u>J.W. Bird, M.D.</u>  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL, <u>Crementation</u>  |                           | 22b. DATE THEREOF <u>10/21/58</u>  |                                   | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>   |                                     | 22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u>  |                           |  |                                   | 24a. REC'D BY REGISTRAR <u>Oct 22 '58</u>   |                                     | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11461

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

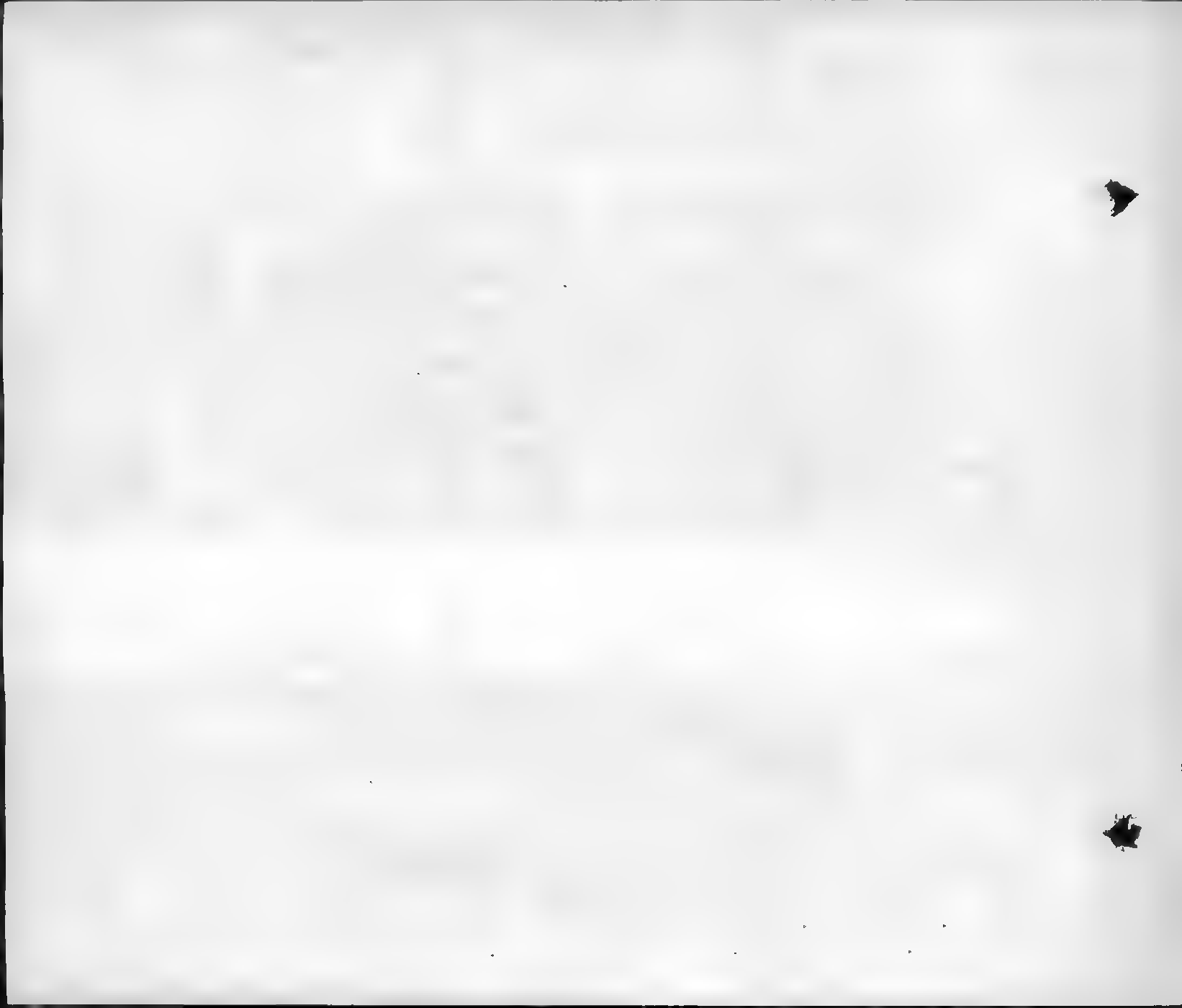
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>N.Y.</u> b. COUNTY <u>Westchester</u>                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Yonkers</u>   |  |
| c. LENGTH OF STAY IN 1b<br><u>6 hours</u>  |   | d. STREET ADDRESS<br><u>112 Ramsey Ave.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium and Hospital</u>  |   | e. IS RE-DECEASED ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Thornton</u> Middle <u>Anthony</u> Last <u>Sullivan</u>   |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>22</u> Year <u>1958</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | 8. DATE OF BIRTH<br><u>Nov. 25, 1892</u>                                   |
| 9. AGE (In years last birthday)<br><u>65 yrs</u>   |   | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>22</u>  | 11. IF UNDER 24 HRS<br>Hours <u>0</u> M n <u>00</u>                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Commander, U.S. Coast Guard (retired)</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Brooklyn, N.Y.</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Cornelius A. Sullivan</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Laura Frances Chadwick</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><u>Yes WW 1 &amp; 2</u>  |   | 16. SOCIAL SECURITY NO<br><u>?</u>   |  |
| 17. INFORMANT<br><u>Lillian Sullivan (wife)</u>  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4-- DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u><br>DUE TO (c) <u>                    </u>   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>                    </u> a. m. <u>                    </u> p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>   |   | DATE SIGNED <u>10-20-58</u>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Trans. &amp; Burial</u>  | 22b. DATE THEREOF<br><u>Oct. 21, 1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>KENSICO CEMETERY</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>VALHALLA, NEW YORK</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond A. Zieba</u>  |   | 24a. REC'D BY REGISTRAR<br><u>                    </u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>                    </u>  |   | DATE<br><u>OCT 22 1958</u>   |  |

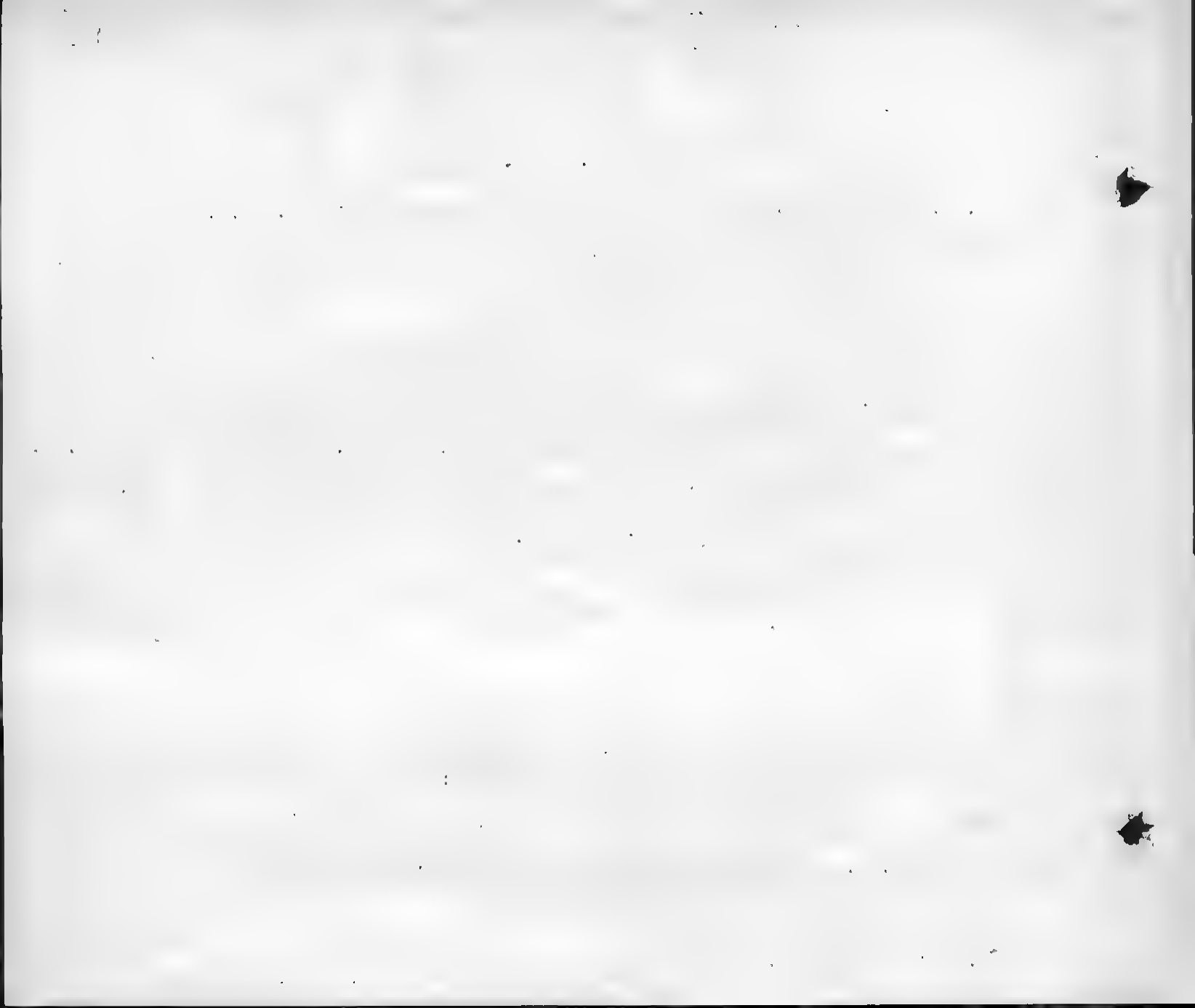
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 215

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>     |  | c. LENGTH OF STAY IN 1b<br><b>1yr 2mos.</b>   |  | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |  | d. STREET ADDRESS<br><b>2310 Connecticut Ave., N.W.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Anna</b>   |  | First<br><b>Huber</b>   |  | Middle<br><b>SYMPHER</b>  |  | Last  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2-5-73</b>   |  |
| 9. AGE (In years last birthday)<br><b>85</b> yrs  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Rhode Island</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Bartlett J. CROMWELL</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lizzie Stiles HUBER</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |  | 17. INFORMANT<br><b>(D) Miss Elizabeth C. Sypher</b>  |  | Address <b>Chasleton Hotel Washington, D. C.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>331X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>(b) <b>Arteriosclerosis, generalized</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis, chronic</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 21</b> , 19 <b>58</b> , to <b>October 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>October 9</b> , 19 <b>58</b> , and that death occurred at <b>8:35 P.M.</b> , from the causes and on the date stated above   |  | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital, NMMC</b>                                      |  | DATE SIGNED<br><b>10-10-58</b>  |  |   |  |
| ACTUAL SIGNATURE <b>W. J. Jacoby, Jr.</b> M.D.  |  | PHYSICIAN'S NAME (Type) <b>W. J. JACOBY, JR., LCDR MC USN</b>   |  | Bethesda 14, Maryland   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10-14-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jos. Gawler's &amp; Sons</b>   |  | ADDRESS<br><b>1756 Penna Ave, NW, Wash, D.C.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>OCT 14 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Carroll S. Frame</i>   |  |



# CERTIFICATE OF DEATH

11579

## MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/55



11585

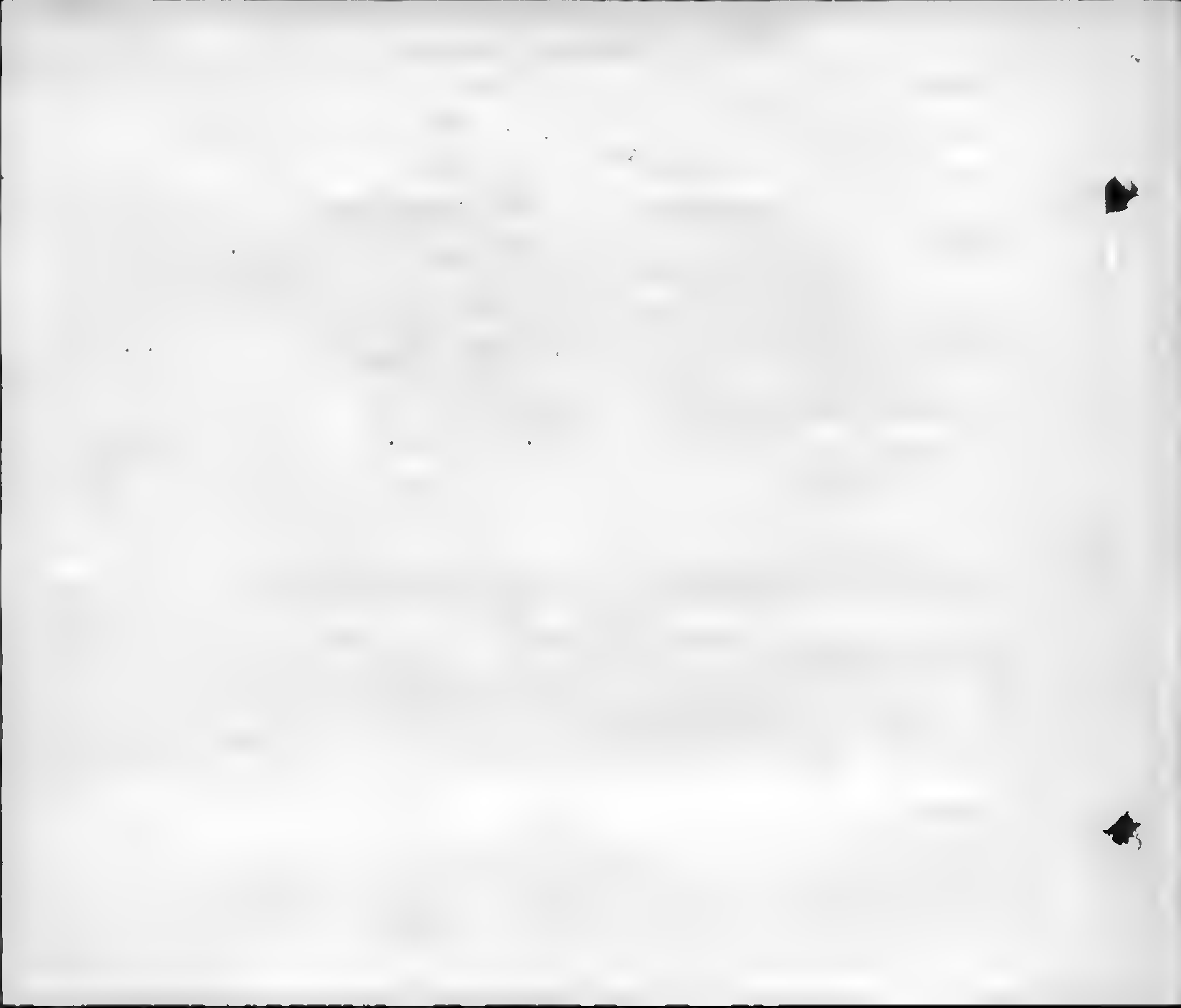
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |   |   |   |   |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont</u> <u>Montgomery</u> <u>MARYLAND</u>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  |   | c. LENGTH OF STAY IN 1b<br><u>14 hours</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>SUBURBAN Suburban Hospital</u>   |                                  |   |   | d. STREET ADDRESS<br><u>5504 Lincoln Street</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ernest</u> Middle <u>LeRoy</u> Last <u>Thompson</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>21</u> Year <u>19 58</u>  |   |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>December 5, 1897</u> |   | 9. AGE (In years last birthday)<br><u>60</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>16</u>  | IF UNDER 24 HRS<br>Hours <u>10</u> Min. <u>16</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired - Policeman</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Police Dept.</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Rockville, Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Unknown</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u> (An orphan)  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>WWI</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>None</u>   |   | 17. INFORMANT<br><u>Wife</u>  |   | Address<br><u>Mrs. Beatrice H. Thompson As above</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, Acute</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO (c) |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>ONE DAY</u><br><u>YEARS</u>                                |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |   |   |
| 20c. TIME OF INJURY<br>Hour <u>19</u> Month, Day, Year<br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>7:00</u> <u>7</u> <u>1953</u> , to <u>0CT 21</u> <u>1958</u> , that I last saw the deceased alive on <u>0CT 21</u> <u>1958</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.  |                                  |   |   |   |   |   |   |
| ACTUAL SIGNATURE <u>DEWITT E. DELAUNTER</u> M.D.  |                                  |   |   | ADDRESS (Street, city or town, state)<br><u>8025 ABERDEEN RD Bethesda, Md</u>   |   | DATE SIGNED<br><u>10/22/58</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>DEWITT E. DELAUNTER</u>   |                                  |   |   | <u>Bethesda, Md</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |                                  | 22b. DATE THEREOF<br><u>10/23/58</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Suitland, Maryland</u>                        |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |                                  |   |   | ADDRESS<br><u>Bethesda, Maryland</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 23 '58</u>   |   |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>William S. Finner</u>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11581

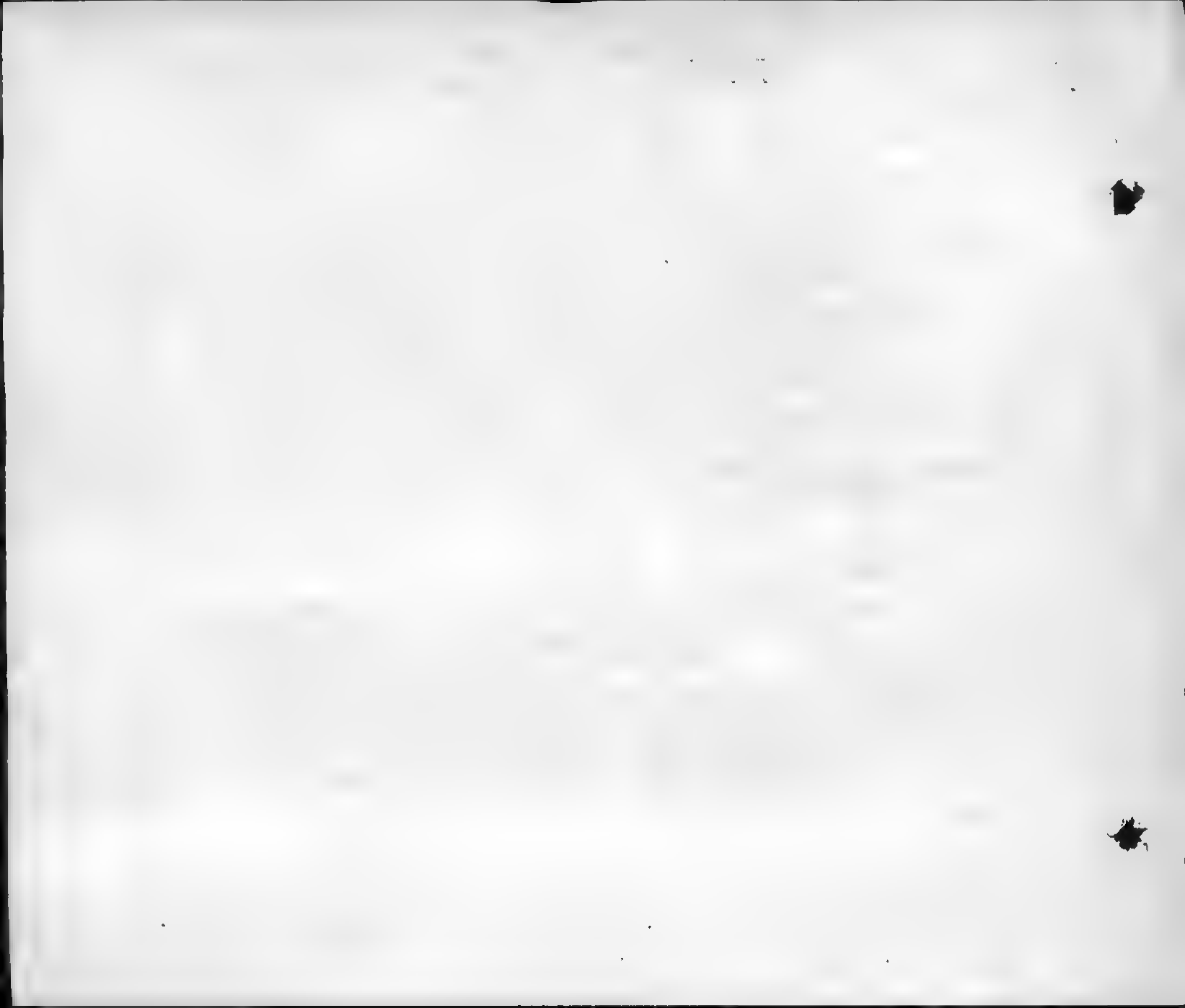
11586

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a STATE <u>md</u> b COUNTY <u>Montg</u>                          |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |                               | c. LENGTH OF STAY IN 1b <u>20 yrs</u>  |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3905 Sand Rd</u>   |                               | e. STREET ADDRESS <u>3905 Sand Rd</u>  |                                 |
| 3 NAME OF DECEASED (Type or print) <u>Neellie May Tipton</u>   |                               | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>18</u> Year <u>1958</u>  |                                 |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-3-04</u> |
| 9. AGE (In years last birthday) <u>53 yrs</u>  |                               | 10. IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>3</u>   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Elem. School</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>   |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                 |
| 13. FATHER'S NAME <u>Elmer Beas</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Jeannie Stone</u>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>  |                               | 16. SOCIAL SECURITY NO <u>Harold Tipton</u>  |                                 |
| 17. INFORMANT <u>Harold Tipton</u>   |                               | Address <u>Same as Tipton</u>  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |                                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o m p m   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                               |  |                                 |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                 |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>10/21/58</u>  |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>  |                               | 24a. REC'D BY REGISTRAR <u>Oct 20 1958</u>   |                                 |
| 24b. REGISTRAR'S SIGNATURE <u>W. W. W.</u>   |                               | DATE <u>10-18-58</u>   |                                 |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11587 CERTIFICATE OF DEATH

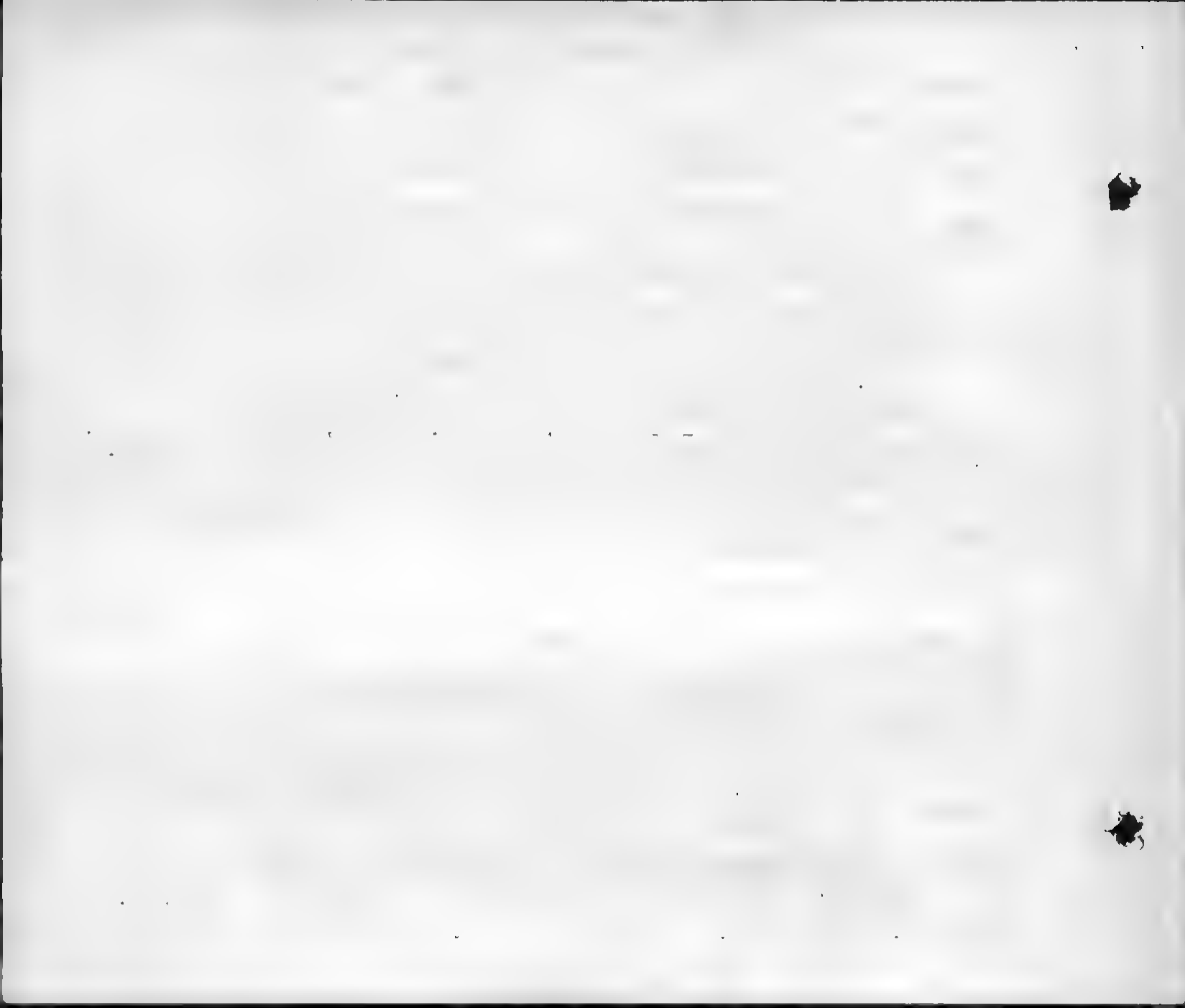
11582

Reg. Dist. No.

|  |                                      |   |  |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>15 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SUBURBAN</b>  |                                      | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10216 Colesville Rd.—Silver Spring</b>                               |  |
|  |                                      | f. STREET ADDRESS<br><b>10210 Colesville Rd.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALICE</b> Middle <b>Marie</b> Last <b>TRAVISS</b>  |                                      | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>12</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 11, 1914</b>                                      |
| 9. AGE (In years last birthday)<br><b>44</b> yrs.  |                                      | 10. IF UNDER 1 YEAR: IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>William Mc Guire</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Sheehan</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                      | 16. SOCIAL SECURITY NO.<br><b>207-01-2150</b>   |  |
| 17. INFORMANT<br><b>Mr. Harvey E. Traviss, 10210 Colesville Rd, Silver Spring, Md.</b>   |                                      | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                      |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma of breast</b>   |                                      |   |  |
| 170X DUE TO  |                                      |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                                      |   |  |
| (b) <b>Carcinoma Breast</b>  |                                      |   |  |
| DUE TO   |                                      |   |  |
| (c)  |                                      |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.  | Month, Day, Year<br><b>19</b>        | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |
| 20f. (City or town)  |                                      | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>August 20, 1958</b> to <b>Oct 11, 1958</b> , that I last saw the deceased alive on <b>Oct 11, 1958</b> , and that death occurred at <b>11:58 P.M.</b> from the causes and on the date stated above. |                                      |   |  |
| ACTUAL SIGNATURE <b>George Sharpe</b>  |                                      | ADDRESS (Street, city or town, state) <b>10511 Summit Ave. Kensington, Md. 10-12-58</b>   |  |
| PHYSICIAN'S NAME (Type) <b>George Sharpe MD</b>  |                                      | DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>10/15/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN CEMETERY</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond A. Guska</b>  |                                      | 24a. REC'D BY REGISTRAR<br><b>OCT 14 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Robert S. Hines</b>   |                                      |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11588

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                 |  |  |  |  |
|---|-------------------------------|--|---------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>  |                               |  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>                               |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>md R-124</u>  |                               |  |                                 | d. STREET ADDRESS <u>md R-124</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Jessie</u> Middle <u>Randolph</u> Last <u>Vollmer</u>   |                               |  |                                 | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>21</u> Year <u>1958</u>  |  |  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-3-69</u> |  | 9. AGE (In years last birthday) <u>88</u> yrs. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Mrs. Melbourne F. Watson</u>   |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <u>Mary Rysawick</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT <u>Eliz Mainhart</u>   |  | Address <u>Stem 2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>malnutrition</u><br>DUE TO (c) |                               |  |                                 |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hr</u><br><u>2 mo.</u>                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                 |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>   |                               |  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |  |
|   |                               |  |                                 | 20f. (City or town)  |  | (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>11-23</u> to <u>11-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-20</u> , 19 <u>58</u> , and that death occurred at <u>9:4</u> A. M., from the causes and on the date stated above.  |                               |  |                                 |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |                               |  |                                 | DATE SIGNED <u>8 Russell Ave</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>FRANK J. Broschart</u>   |                               |  |                                 | <u>Gaithersburg, Md</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>11-24-58</u>  |                                 | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>30th + R St. Washington, D.C.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett B. Garton</u> ADDRESS <u>Gaithersburg, Md</u>  |                               |  |                                 | 24a. REC'D BY REGISTRAR <u>DATE OCT 24 58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



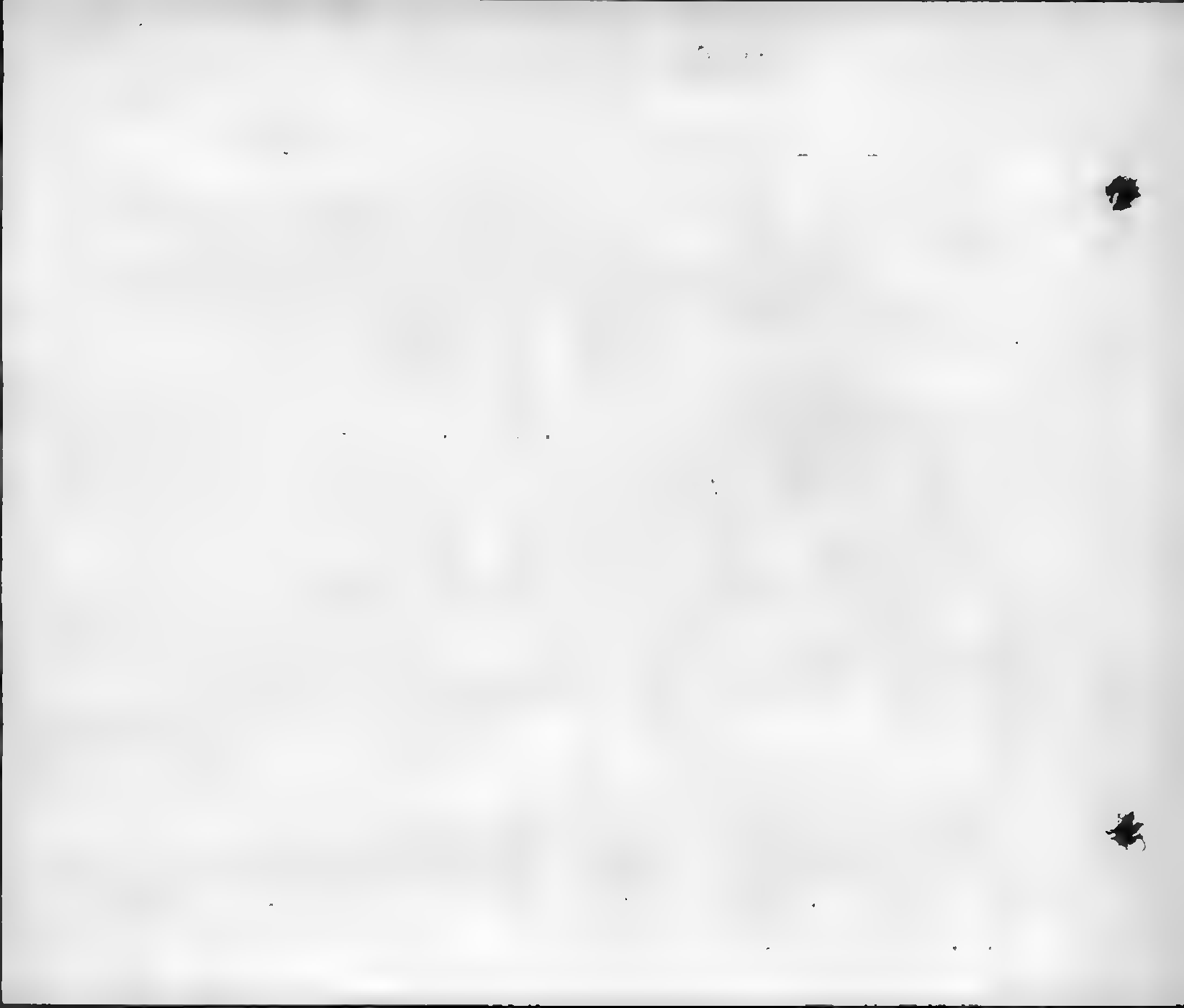
## 11589 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |   |  |   |   |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Germantown-Rural-Box 199</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>Months</b>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Near Germantown</b>   |                                  |   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Germantown-Rural-Box 199</b>                           |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Near Germantown</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Near Germantown</b>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Annie</b> Middle <b>Luray</b> Last <b>Wachter</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>1958</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 15, 1892</b> | 9. AGE (In years last birthday) yrs.<br><b>66</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min |   | IF UNDER 24 HRS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |   |
| 13. FATHER'S NAME<br><b>Thadeus Filby</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Horzeanie Wilson</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT<br><b>Mr. Bruce E. Wachter-Same as item #2</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>443X</b> DUE TO <b>Pulmonary Edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b><br>(c) <b>Chronic Myocarditis</b>   |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  |   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |   |
|   |                                  |   |   | 20f. (City or town)   |  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1955</b> , 19 <b>Oct 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 5</b> , 19 <b>58</b> , and that death occurred at <b>11:45 P.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>108 N. Frederick Ave.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Luciano I. Leal</b> M.D. <b>108 N. Frederick Ave.</b><br>PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b> <b>Gaithersburg Md.</b> |                                  |   |   |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 15, 1958</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frederick Memorial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 16 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Wm. S. Frank</b>                           |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





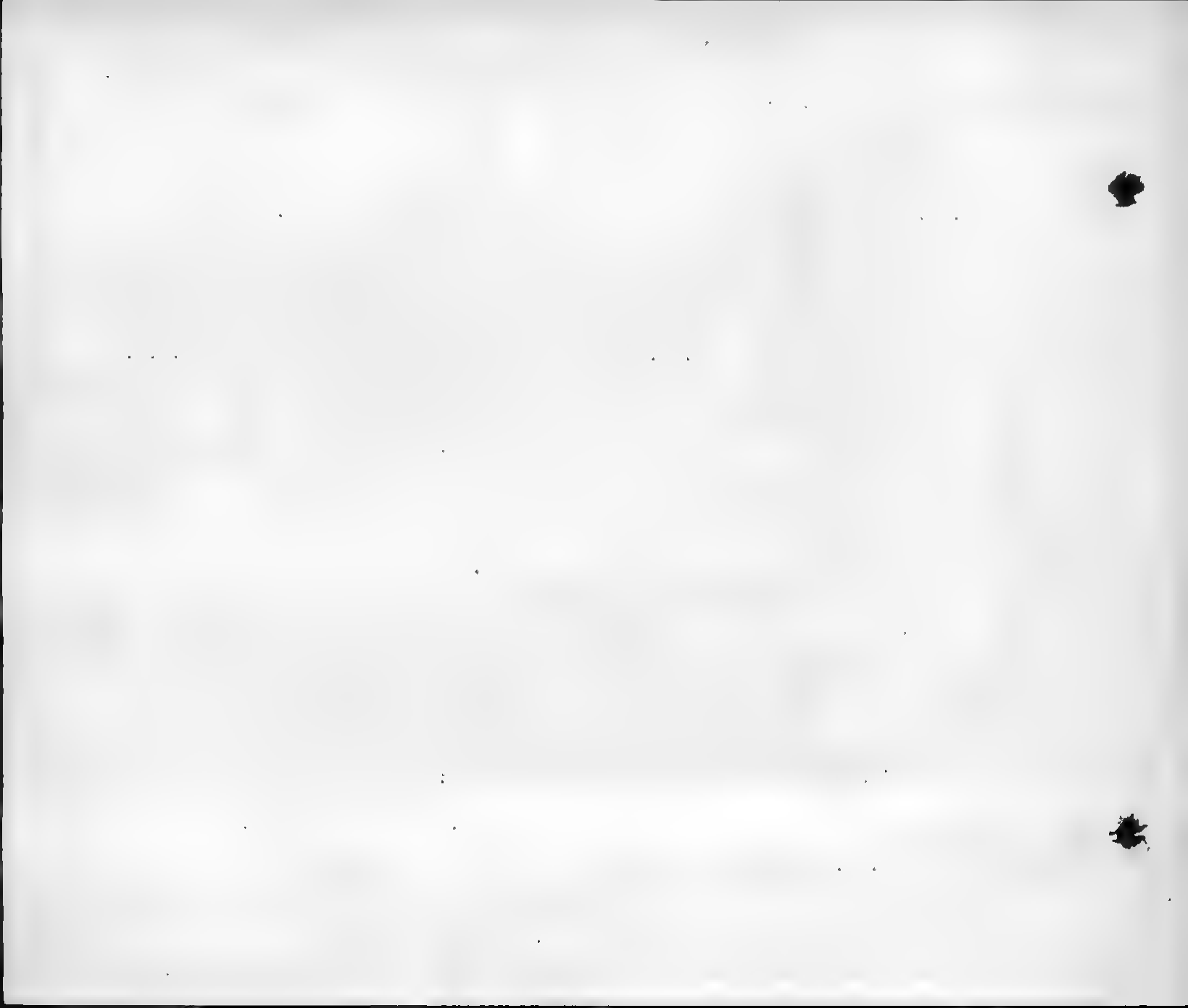
11590

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  |   | c. LENGTH OF STAY IN lb<br><b>50 days</b> |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>Falls Church</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>6004 Arlington Blvd.</b>  |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>John Rodney</b>   |                                  | First Middle Last<br><b>WALLACE, Jr.</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 6 1958</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-23-82</b>        |   | 9. AGE (In years last birthday)<br><b>76</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mariner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Navy</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Tennessee</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Rodney WALLACE</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Frances LITTLE</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWI</b>   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Wife, Mrs. Nellie V. Wallace, same as #2</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis, acute</b><br><b>153.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Leakage at anastomosis site</b><br>DUE TO <b>Post-operative bowel resection for adenocarcinoma of transverse colon</b><br>(c) <b>of transverse colon</b> |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>Unknown</b><br><b>10 days</b>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic Heart Disease</b>  |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>                             |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>August 18, 1958</b> , to <b>October 6, 1958</b> , that I last saw the deceased alive on <b>October 6, 1958</b> , and that death occurred at <b>2:25 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>U. S. Naval Hospital, NMMC Bethesda, Maryland 10-6-58</b>  |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>J. W. Troy</b>  |                                  | M D <b>U. S. Naval Hospital, NMMC Bethesda, Maryland</b>  |   |   |   |   |  |
| PHYSICIAN'S NAME (Type)<br><b>J. W. TROY CDR MC USN</b>   |                                  |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-9-58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>                                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ives Funeral Home, 2847 Wilson Blvd., Arlington</b>  |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 9 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>C. J. S. Evans</b>   |  |

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11591

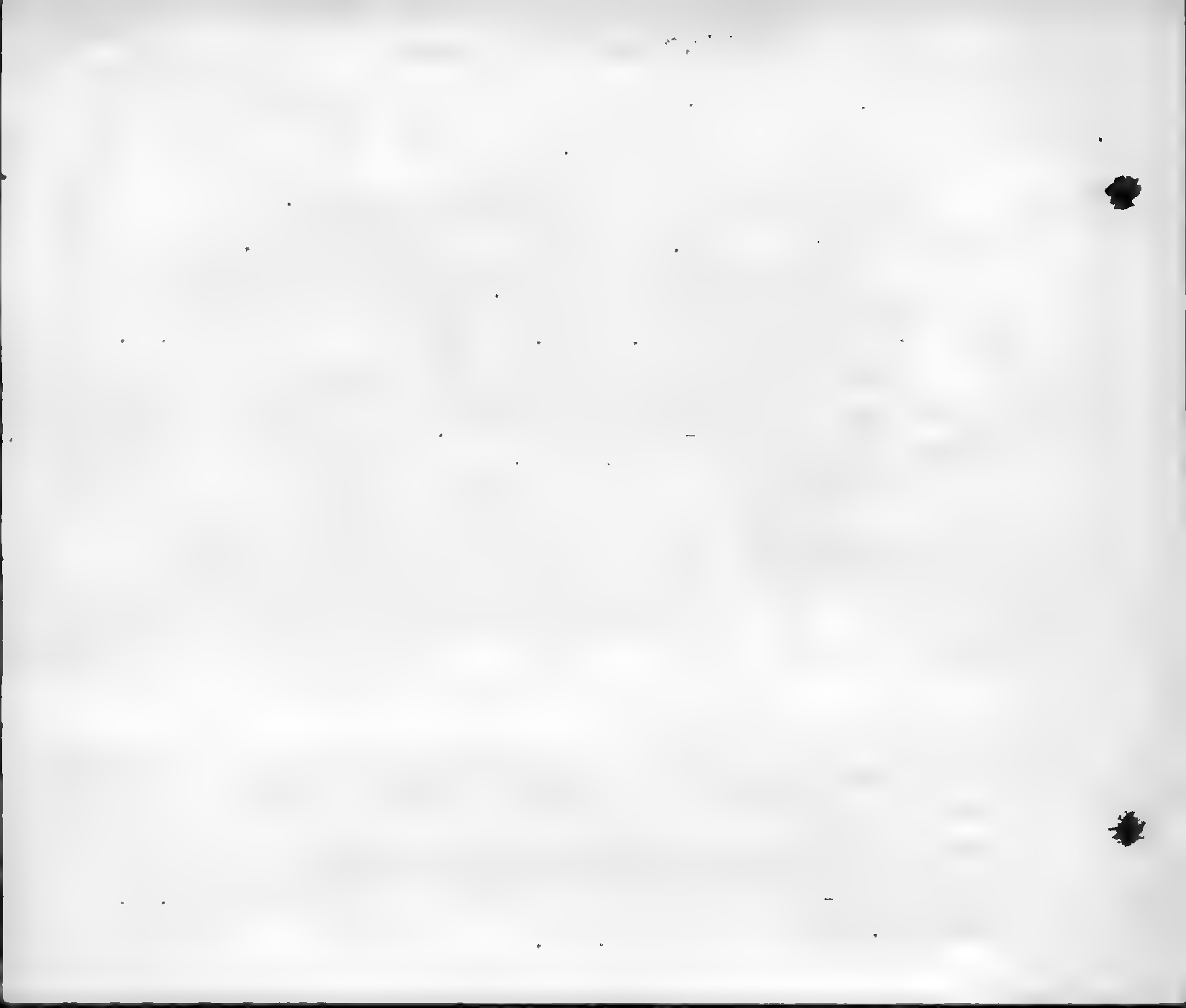
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |   |
| c. LENGTH OF STAY IN TB<br><b>2½ Months.</b>  |                                      |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>9301 Weaver Street</b>   |                                      | d. STREET ADDRESS<br><b>9301 Weaver St.</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>EDWIN</b> First <b>H.</b> Middle <b>WALKER</b> Last   |                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>9,</b> Year <b>1958</b>  |   |
| 5 SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Nov. 24, 1873</b>                                  |
| 9. AGE (In years, months, days, hours, minutes)<br><b>84</b> yrs. <b>10</b> months <b>15</b> days <b></b> hours <b></b> min.  |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Printers Supply Co. - Pres.</b>                  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>William Calvin Walker</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Selby Harvey</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or date of service)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO<br><b>578-38-8874</b>  |   |
| 17. INFORMANT<br><b>Son</b>   |                                      | 18. ADDRESS<br><b>4504 Wetherill Rd. Westmoreland Hills, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO <b>arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 yrs</b><br>(c) <b>1 1/2 hr</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hr</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b>   |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o. m. p. m.  |                                      | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1954</b> to <b>Oct 9, 1958</b> , that I last saw the deceased alive on <b>Oct 7, 1958</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>401 Kennedy St NW Wash. D.C.</b> DATE SIGNED <b>Oct 10, 1958</b>     |                                      |   |   |
| ACTUAL SIGNATURE<br><b>M.F. OTTMAN</b>  |                                      | M.D. <b>401 Kennedy St NW Wash. D.C.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>M.F. OTTMAN</b>   |                                      |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10-13-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b> |
| 23. FUNERAL HOME OR SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |                                      | ADDRESS<br><b>Bethesda, Md.</b>   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>                         |
|   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Fouse</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11462

CERTIFICATE OF DEATH

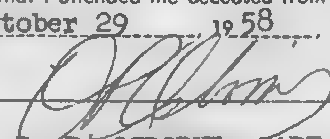

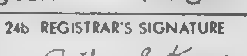
Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>3 hr. 45 min.</u>   |  |   |  | d. STREET ADDRESS <u>7511 Maple Ave.</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Preston Edward Walter</u>   |  |   |  | 4. DATE OF DEATH <u>October 2, 1958</u>  |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>9-21-44</u>  |  |
| 9. AGE (In years last birthday) <u>14</u> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                     |  |
| 13. FATHER'S NAME <u>Fred D. Walter</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Margueriet Cooley</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>Hospital Record</u> Address                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u>  |  |   |  |  |  |  |  |
| 237X DUE TO  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  |  |   |  |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  |
|  |  |   |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>Sept. 26, 1958</u> , to <u>Oct. 2, 1958</u> , that I last saw the deceased alive on <u>Oct. 2, 1958</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>A. F. Whitbread</u>  |  |   |  | ADDRESS (Street, City or town, state) <u>10111 Colasville Rd. Silver Spring, Md.</u>   |  |  |  |
| DATE SIGNED <u>11/2/58</u>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>A. F. Whitbread</u>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>Oct. 6, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>   |  | 22d. LOCATION (City or town, or county) (State) <u>Prince George's Co. Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Davis</u> ADDRESS <u>12 D.C. 254 Carroll ST. N.W.</u>  |  |   |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>John S. Kraus</u>                                |  |

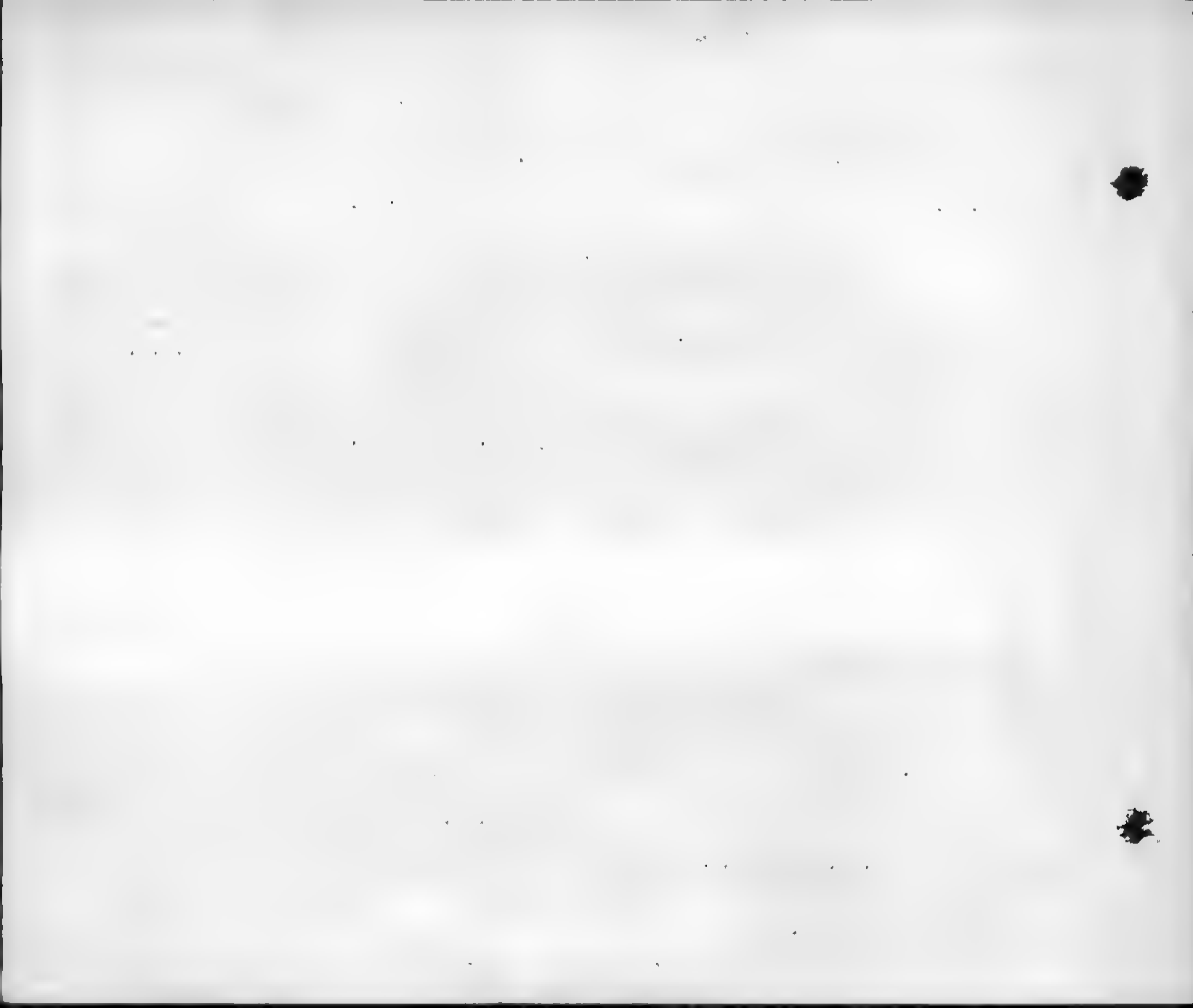


## 11592 CERTIFICATE OF DEATH

Reg. Dist. No. 215

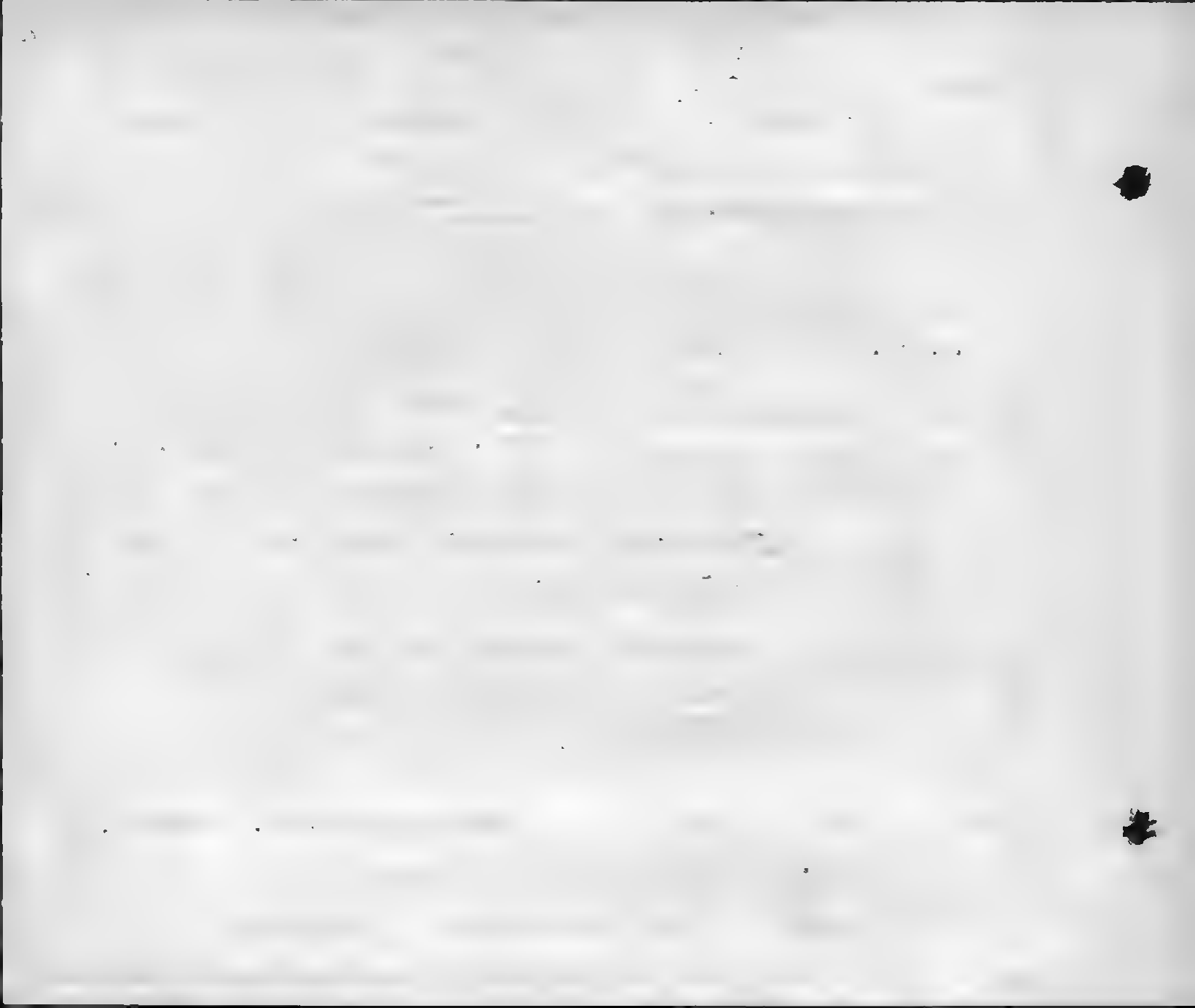
|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>28 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Pennsylvania</b><br>b. COUNTY<br><b>Drexel Hill</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Drexel Hill</b><br>d. STREET ADDRESS<br><b>1112 Mason Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Henry Charles WEBER</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 30 1958</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2-4-87</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Doctor of Medicine</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Medicine</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William WEBER</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Frances TREESE</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown)<br><b>Yes</b>  |   | 16. SOCIAL SECURITY NO.<br><b>163-28-5980A</b>  |   |
| 17. INFORMANT<br><b>(W) Mrs. Mabelle R. Weber, same as #2 above</b>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Large retroperitoneal liposarcoma</b><br><b>197.9</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>Additional diag - Large perigastric neurofibroma, right</b><br>(b) <b>1 + yrs.</b><br>(c) <b>4 + yrs.</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 + yrs.</b><br><b>1 + yrs.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>October 2, 1958</b> to <b>October 30, 1958</b> , that I lost s/he the deceased alive on <b>October 29, 1958</b> , and that death occurred at <b>3:35A</b> M, from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br>   |   | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital, NNMC</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>D. P. OSBORNE, CAPT, MC, USN</b>  |   | DATE SIGNED<br><b>10-30-58</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>11-3-58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><br>ADDRESS<br><b>Adams Funeral Home, 4748 Wisc. Ave., NW, Wash.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DEC 3 '58</b>   | 24b. REGISTRAR'S SIGNATURE<br> |

TO BE SIGNED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.





|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>a. STATE<br><b>Maryland</b>                                      |  | b. COUNTY<br><b>Montgomery</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. LENGTH OF STAY IN lb<br><b>2 months</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Green Acres</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ropine Care Home 7927 Wis. Ave.</b>   |  |   |  | d STREET ADDRESS<br><b>4922 Greenway Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>HATTIE</b>  |  | First<br><b>I</b>   |  | Middle<br><b>WEISEL</b>  |  | Last<br><b>1958</b>  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF DEATH<br>Month <b>Oct</b> Day <b>4</b> Year <b>1958</b>                     |  |
| 9. AGE (In years last birthday) yrs.<br><b>84?</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  | 11. IF UNDER 24 HRS<br>Months Days Hours Min   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U.S. Govt.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Census</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown Wyoming</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>DANIEL WEISEL</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Isabel Waters</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO  |  | 17. INFORMANT<br>Address<br><b>Robt L. Waters 4922 Greenway Drive, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Hemorrhage Gastro-Intestinal Massive</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Thrombo-Phlebitis, Left Leg Ascending</b><br>DUE TO<br>(c) <b>Arterio Sclerosis-Severe-Generalized</b> |  |   |  |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21 I certify that I attended the deceased from <b>4 Oct. 1958</b> , to <b>4 Oct 1958</b> , that I last saw the deceased alive on <b>4 Oct 1958</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7936 Georgetown Road, Bethesda 14, Md.</b> DATE SIGNED <b>10/4/58</b>                                   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>  |  | M.D. <b>7936 Georgetown Road, Bethesda 14, Md.</b>  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>John G. Ball</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 22b. DATE THEREOF<br><b>10/5/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Md.</b>                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>JOSEPH F. BURKINS</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>ACT 6 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>C. H. &amp; K. H.</b>                                 |  |



11590

Reg. Dist. No. 215

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b> |  | c. LENGTH OF STAY IN 1b<br><b>33 days</b>  |  | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b>         |  | b. COUNTY<br><b>Prince Georges</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, NMMC</b>  |  |   |  | d. STREET ADDRESS<br><b>4503 Emerson Street</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Herbert</b>  |  | First<br><b>Talmage</b>   |  | Middle<br><b>WHITESELL</b>   |  | Last  |  | 4. DATE OF DEATH<br>Month<br><b>October</b>   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | 8. DATE OF BIRTH<br><b>10-4-90</b>  |  | 9. AGE (In years last birthday) yrs<br><b>68</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Conductor</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>D.C. Transit</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | IF UNDER 1 YEAR<br>Months<br><b>18</b>  |  |
| 13. FATHER'S NAME<br><b>David WHITESELL</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice HALL</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO<br><b>12/1918-9/1919 Unknown</b>   |  | 17. INFORMANT<br><b>(D) Mrs. Edith M. Meals, same as #2 above</b>                                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b><br>DUE TO <b>Cachexia, marked, due to mental deterioration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Syphilis, tertiary, tabes dorsalis</b><br>(c) <b>Syphilis, tertiary, tabes dorsalis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>6 mos.</b><br><b>15 1/2 years</b>                   |  | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hypertensive Vascular Disease, benign</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)<br><b>(County)</b><br><b>(State)</b>  |  | 20g. (City or town)<br><b>(County)</b><br><b>(State)</b>  |  | 20h. (City or town)<br><b>(County)</b><br><b>(State)</b>   |  | 20i. (City or town)<br><b>(County)</b><br><b>(State)</b>  |  | 20j. (City or town)<br><b>(County)</b><br><b>(State)</b>  |  |
| 21. I certify that I attended the deceased from <b>September 15 19 58</b> , to <b>October 18, 1958</b> , that I last saw the deceased alive on <b>October 17, 1958</b> , and that death occurred at <b>4:15 A.M.</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |  |   |  |
| ACTUAL  |  | ADDRESS (Street, city or town, state)<br><b>F. S. CALDWELL, LT, MC, USN Bethesda 14, Maryland</b>           |  | DATE SIGNED<br><b>10-18-58</b>   |  | M.D.<br><b>U. S. Naval Hospital, NMMC</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10-21-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Arlington Virginia</b>  |  | (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis Gasch's Sons Funeral Home, Hyattsville,</b>  |  | ADDRESS<br><b>Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 21 1958</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Robert S. Evans</b>  |  |   |  |



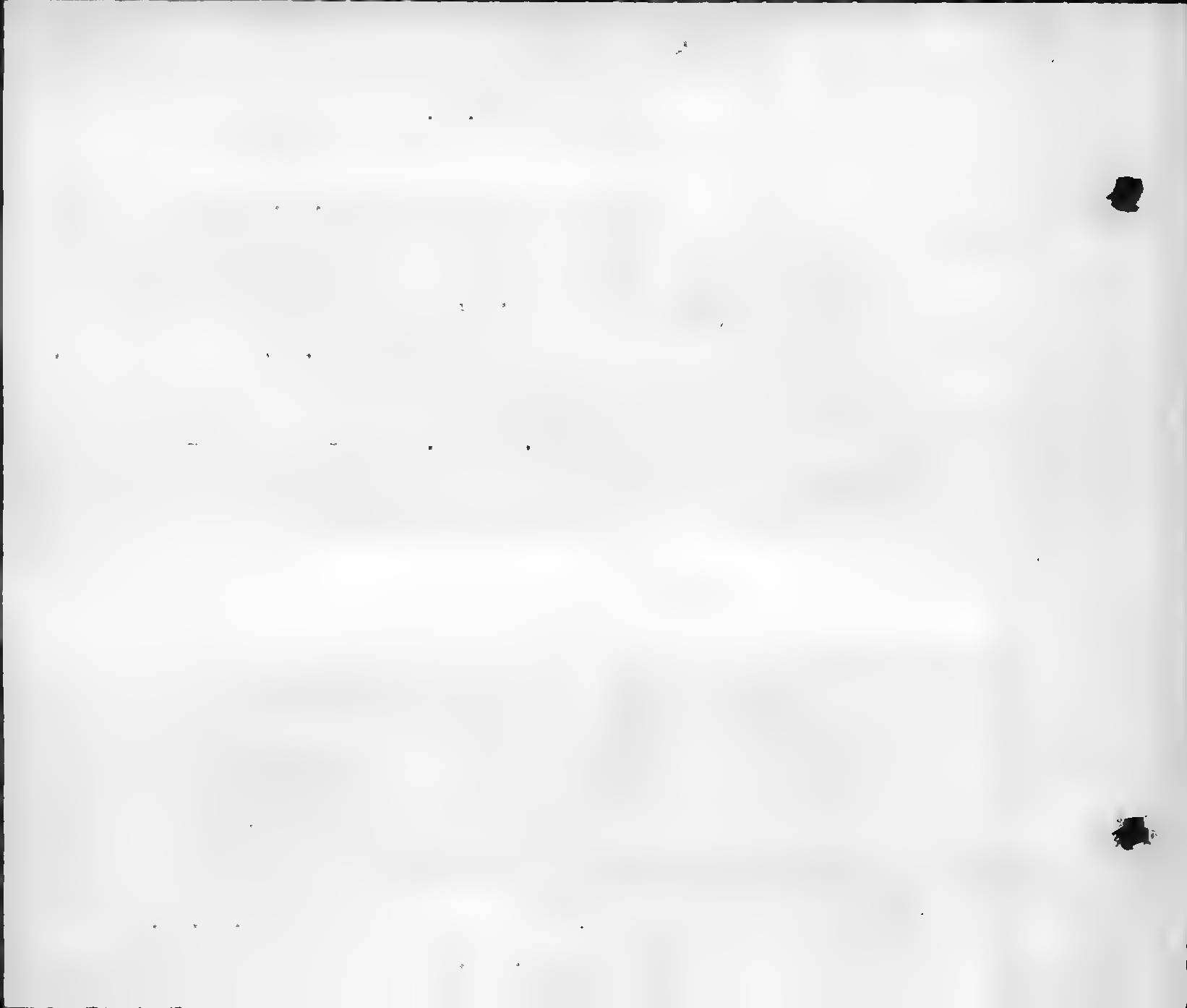
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11595 CERTIFICATE OF DEATH

11591

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>D. C.</b><br>b. COUNTY<br><b>Washington</b>       |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kensington Gardens Nursing Home</b>   |                                  | d. STREET ADDRESS<br><b>3821 Kanawha St. N. W.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Gertrude West Williamson</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 30, 1958</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 28, 1888</b> |
| 9. AGE (In years last birthday)<br><b>69</b>   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>John Thomas West</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude Phelps</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mrs. John F. Splain—same as 2-d</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary S. Disease</b><br>(c) <b>atherosclerosis of the coronary arteries</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 hours</b><br><b>5 yrs</b><br><b>1 yr</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary Thrombosis</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Jan 1, 1945</b> to <b>Oct 30, 1958</b> , that I last saw the deceased alive on <b>Oct 29, 1958</b> , and that death occurred at <b>2:30 P. M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>10301</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Horace H. Custis, Jr.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>1852 Columbia Road, Washington, 9, D. C.</b> |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11/1/58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Frank J. Williams</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE NOV 3 '58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |                                  |  |  |



11463

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                  |  |  |  |   |
|--|----------------------------------|---|----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i><br><i>Wash D.C.</i><br>MARYLAND   |                                  |   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Wash D.C.</i><br>b. COUNTY <i>Washington D.C.</i> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Takoma Park Md.</i>   |                                  |   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Washington D.C.</i>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><i>Wash. State Hospital</i>   |                                  |   |                                  | d. STREET ADDRESS<br><i>Sheraton Park Hotel</i>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Ida</i> Middle <i>Frances</i> Last <i>Wilmoth</i>  |                                  |   |                                  | 4. DATE OF DEATH<br>Month <i>10</i> Day <i>19</i> Year <i>1958</i>   |  |  |   |
| 5. SEX<br><i>Fe</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>8/7/3</i> | 9. AGE (In years last birthday)<br><i>70 + yrs</i>   | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS<br>Hours Min   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (State or foreign country)<br><i>New York</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                          |   |
| 13. FATHER'S NAME<br><i>Abrams Shotwell</i>  |                                  |   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Elmira Clark</i>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>  |                                  | 16. SOCIAL SECURITY NO<br><i>none</i>   |                                  | 17. INFORMANT<br>Address   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial infarction, myocardial hypertrophy</i><br>DUE TO <i>Coronary atherosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerosis</i><br>DUE TO <i>Arteriosclerosis</i><br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Salt stress, Osteoporosis</i> |                                  |   |                                  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>   |                                  |   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)   |                                  |   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 21. I certify that I attended the deceased from <i>1940</i> , 19____, to <i>10/19/</i> , 19 <i>58</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.   |                                  |   |                                  |  |  |  |   |
| ACTUAL SIGNATURE<br><i>H. H. Wolochin</i><br>M.D.  |                                  |   |                                  | ADDRESS (Street, city or town, state)<br><i>7600 Carroll St Takoma Park Md</i>   |  |  |   |
| DATE SIGNED<br><i>10/19/58</i>   |                                  |   |                                  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>10-22-58</i>  |                                  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>Suitland Md.</i>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Lee Funeral Home + Mary Ann Mc</i>  |                                  |   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <i>OCT 22 '58</i>  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>                   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





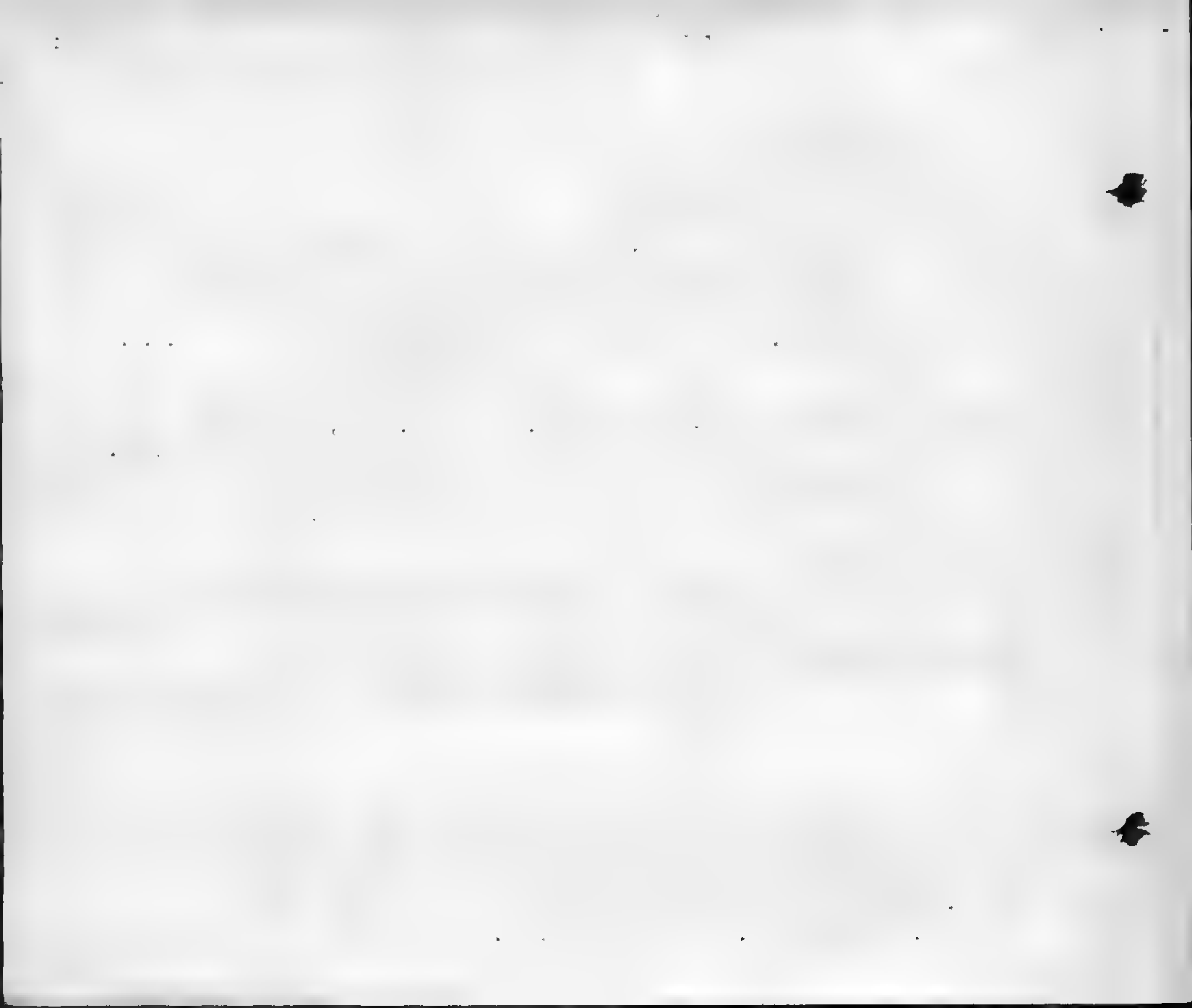
## 11596 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |   |  |  |  |
|--|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |   |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>                                      |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1915 PLYERS MILL ROAD</b>   |   |   |  | d. STREET ADDRESS<br><b>1915 PLYERS MILL ROAD</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MELVIN</b> Middle <b>P.</b> Last <b>WOLF</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>25</b> Year <b>19 58</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/11/04</b>                                       | 9. AGE (In years last birthday)<br><b>54 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min         | IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BUYER, Hechinger Co.</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building Supplies</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>ALABAMA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>OTTO WOLF</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>SARAH PACH</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>NO</b> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO<br><b>578-05-9264</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs. Pearl M. Wolf, 1915 Pliers Mill Road Silver Spring, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOGENIC CARCINOMA WITH METASTASES</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b><br><b>1 YEAR</b> |   |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)  | (State)  |  |  |
| 21. I certify that I attended the deceased from <b>Aug.</b> 1957, to <b>OCT. 25, 1958</b> , that I last saw the deceased alive on <b>OCT. 25, 1958</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7723 ALASKA AVE NW WASH DC</b> DATE SIGNED <b>Robert L. Krichmar</b>   |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Robert L. Krichmar</b> M.D.  |   | PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR M.D.</b> <b>WASH DC</b>   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>TRANS. &amp; BURIAL</b>  | 22b. DATE THEREOF<br><b>10/28/58</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>GLENWOOD CEMETERY</b>  | 22d. LOCATION (City, town or county) (State)<br><b>WAVERLY, NEW YORK</b> |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Pumphrey, INC.</b>   |   | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 28 '58</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>W. S. K. K.</b> |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11597 CERTIFICATE OF DEATH

11594

Reg. Dist. No.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>         |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>2 1/2 years</b>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Lebeau Gardens Nursing Home</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>William T Wolgrey, Sr.</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 27 19 58</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Caucasian</b>     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 25, 1865</b>                               |   |
| 9. AGE (In years last birthday) yrs<br><b>93</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plasterer</b>  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  |  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>William T Wolfrey</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Beazley</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO  |  |  |   |
| 17. INFORMANT<br><b>Nursing Home</b>   |  |  |  | Address<br><b>Silver Spring, Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b>   |  |  |  |   |  |  | <b>4 days</b>   |
| DUE TO <b>Arteriosclerosis, Mod Severe</b>   |  |  |  |   |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Thrombosis, right leg</b>   |  |  |  |   |  |  | <b>4 days</b>   |
| DUE TO <b>Old chronic coronary artery disease</b>  |  |  |  |   |  |  |   |
| (c)  |  |  |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
|  |  |  |  | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <b>May 19 56</b> , to <b>Oct 27 19 58</b> , that I last saw the deceased alive on <b>Oct 25 12 58</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above. |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <b>10609 Concord St.</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>   |  |  |  | Kensington, Md.   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 22b. DATE THEREOF<br><b>10/29/58</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.</b>  |  |  |  | ADDRESS<br><b>2901 14th St. N.W. Washington 9, D.C.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 29 58</b>                       |   |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Kraus</b>   |  |  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11598

## CERTIFICATE OF DEATH

Reg. Dist. No.

11595

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>77 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Michigan</b><br>b. COUNTY<br><b>Pontiac</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>59X-3</b><br>d. STREET ADDRESS<br><b>375 East Sheffield Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Betty Maxine Woods</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>March 11, 1927</b>                                  |
| 9. AGE (In years last birthday)<br><b>31</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>17</b> Hours <b>3</b> Min.  | 11. IF UNDER 24 HRS.<br>Months <b>1</b> Days <b>17</b> Hours <b>3</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Michigan</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Monroe Millstead</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Elsie Bennard</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>  |  |
| 17. INFORMANT<br><b>The Medical Record</b>   |   | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>X CEREBRAL EDEMA</b><br><b>173X</b><br>DUE TO <b>X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>METASTATIC CHORIOCARCINOMA</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MONTH</b><br><b>6 MONTHS</b>  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <b>August 8, 1958</b> , to <b>October 24, 1958</b> , that I last saw the deceased alive on <b>October 24, 1958</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above.<br><b>4:45</b> ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br>DATE SIGNED <b>10/24/58</b><br>ACTUAL SIGNATURE <b>Theodore L. Goodfriend, M.D.</b><br>NATIONAL INSTITUTES OF HEALTH<br>Bethesda 14, Maryland<br>PHYSICIAN'S NAME (Type) <b>THEODORE L. GOODFRIEND, MD</b> |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Transit</b>  | 22b. DATE THEREOF<br><b>10/24/58</b>  | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)<br><b>Pontiac, Michigan</b>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 27 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                       |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |
|--|--|
| <p>1. Name of deceased: <i>John Doe</i></p>          |  |
| <p>2. Age: <i>45</i></p>                             |  |
| <p>3. Sex: <i>Male</i></p>                           |  |
| <p>4. Date of death: <i>Jan 15, 1914</i></p>         |  |
| <p>5. Place of death: <i>New York City</i></p>       |  |
| <p>6. Cause of death: <i>Heart Disease</i></p>       |  |
| <p>7. Signature of physician: <i>[Signature]</i></p> |  |
| <p>8. Signature of registrar: <i>[Signature]</i></p> |  |

## 11599 CERTIFICATE OF DEATH

11596

Reg. Dist. No.

|   |                                      |  |                                     |   |  |  |  |
|---|--------------------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |                                      |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                      |  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Suburban Hospital</u>  |                                      |  |                                     | d. STREET ADDRESS<br><u>4918 Auburn Ave</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Baby Girl (Newborn)</u> Middle <u>Yates</u> Last <u>Yates</u>   |                                      |  |                                     | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>21</u> Year <u>1958</u>   |  |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10/19/58</u> |   | 9. AGE (In years last birthday) yrs.<br><u>1</u>                       | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>12</u>      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>  |                                      |  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>          |  |
| 13. FATHER'S NAME<br><u>Douglas B. Yates</u>  |                                      |  |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Hattie Murphy</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                      |  |                                     | 16. SOCIAL SECURITY NO.<br><u>Douglas B. Yates</u>  |  | 17. INFORMANT<br><u>Douglas B. Yates</u>               |  |
|   |                                      |  |                                     | Address <u>4918 Auburn Ave. Bethesda, Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br><u>776x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO<br>(c) _____         |                                      |  |                                     |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                      |  |                                     |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a. m. _____ p. m. _____   | Month _____                          | Day _____  | Year _____                          | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |  |
| 21. I certify that I attended the deceased from <u>20 Oct 1958</u> to <u>20 Oct 1958</u> , that I last saw the deceased alive on <u>20 Oct 1958</u> , and that death occurred at <u>12:51 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ |                                      |  |                                     |   |  |  |  |
| ACTUAL SIGNATURE <u>R. H. Mitchell</u>  |                                      |  |                                     | M.D. <u>Bethesda Md</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>R. H. Mitchell</u>   |                                      |  |                                     |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10/29/58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>  |                                     | 22d. LOCATION (City, town, or county) (State)<br><u>Arlington, Virginia</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey-Bethesda, Maryland</u>  |                                      |  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 28 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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